Towson Pediatrics
Patient Registration

Patient Name _____ Date of Birth_____
Last First Middle

Address:

_____

Sex:_____ Race:_____

Phone Number:_____ Residing with:_____

Mothers Name:_____ Employer:_____

Address:_____

Phone Number:_____ Work Number:_____

Fathers Name: _____ Employer:_____

Address:_____

Phone Number:_____ Work Number:_____

Primary Insurance Carrier:_____

Name of Policy Holder:_____ Date of Birth_____

Relationship to Patient: _____

Policy Number:_____ GroupNumber:_____

Effective Date:_____

Secondary Insurance:_____

Emergency Contact:_____ Relationship:_____

Phone Number:_____ Work Number:_____

****COPY OF FRONT AND BACK OF INSURANCE CARD IS REQUIRED****

Policy Holders Signature:_____ Date:_____

MRN:
Patient Name:

(Patient Label)

Date:

SOCIAL HISTORY

Place of birth:	Language spoken at home:
Name of Mother:	Occupation:
Name of Father:	Occupation:
Other/Guardian:	Occupation:

Who lives at home?

FAMILY HISTORY *(please list your immediate family members below)*

Name	Age	Relationship to patient	Health Problems

Are there any blood relatives who have had any of these problems?

☐ Asthma	☐ Birth Defects	☐ Cancer	☐ Diabetes
☐ Drug/alcohol	☐ High blood cholesterol	☐ High blood pressure	☐ Hyperactivity
☐ Mental retardation	☐ Psychiatric illness	☐ Seizures	☐ Sickle cell disease
☐ Tuberculosis			

BIRTH HISTORY

Name and location of hospital:

Problems during pregnancy:

Birth weight: Full term? ☐ Yes ☐ No Type of Delivery: ☐ Vaginal ☐ Cesarean Section

Problems during or immediately after birth:

Went home after: *(number of days)*

DEVELOPMENT

Please write at which age your child first began to:

Sit alone: Walk alone: Use single words: Toilet trained:

Any school problems now or in the past?

Name of present school: Grade level:

MEDICAL HISTORY

Current Medications:

MRN:
Patient Name:

(Patient Label)

MEDICAL HISTORY *(continued)*	
List any major illnesses, operations or hospitalizations below	Date(s)
1.	
2.	
3.	
4.	
ALLERGIES	
List any reactions your child has to foods, medications, or insects below	
Reviewed by: _____ Date reviewed: _____	

Towson Pediatrics

120 Sister Pierre Drive Suite 305

Towson, Md 21204

Office: 410-769-8801 Fax: 410-769-8803

Demographics

Patient Name and Date of Birth:

Patient Race:

Mother Race:

Father Race:

Patient Primary Language:

Secondary Language:

patient Hispanic or Latino:

Email for Patient Portal:

How did you hear about us?

Towson Pediatrics

Patient authorization personnel

Patient is allowed to be accompanied by and make medical (decisions Parents)

1. Name:_____

   Relationship:_____

   Phone number:_____

2. Name:_____

   Relationship:_____

   Phone number:_____

3. Name:_____

   Relationship:_____

   Phone number:_____

Parents name:

Parents Signature:

Date:

Towson Pediatrics

120 Sister Pierre Drive Suite 305

Towson, Md 21204

Office: 410-769-8801 Fax: 410-769-8803

*Patients Name:*_____ *Date of Birth:*_____

Office Policy Agreement

Date:

I have received a copy of the new office policies and agree to all terms and conditions.

*Parents Name (Print):*_____

*Signature:*_____

Towson Pediatrics Appointment Policy

➢ No Show/ Cancellation Policy -

- We understand that there are times when you must miss an appointment due to emergencies or obligations. However, when you do not call to cancel and/or no show to an appointment you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly full appointment book.
  - *If an appointment is not canceled at-least 24 hours in advance you will be charged $50.00; this fee will NOT be covered by your insurance company.*
  - * If there is No-show to an appointment you will be charged $65.00; this fee will NOT be covered by your insurance company. *

Print Patient Name

Parent/Guardian Signature

Date

TOWSON PEDIATRICS
Patient Registration

PATIENT AUTHORIZATION FORM

PATIENT NAME:_____

AUTHORIZATION TO RELEASE INFORMATION:

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize the release of medical information pertaining to medical treatment requested by my health insurance carrier or the Health Care FInancing Administration and its agencies for determination of benefits coverage.

_____ _____

Authorized Signature **Date**

AUTHORIZATION TO PAY INSURANCE BENEFITS:

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize payment directly to the above named physician, or his/ her billing administration. Otherwise payable to me but not to exceed the regular charges for the services provided. I acknowledge additional charges, and or copay(s) could be associated with well visit once billed to insurance based on services provided that day; and will be held responsible for any additional fees.

_____ _____

Authorized Signature **Date**