Fort Washington Park Pediatrics
Patient Registration Form
Patient Information

Name:_____ Date of Birth_____

Social Security #_____Sex ___M____F

Home Address_____

City_____State_____Zip Code_____

Person filling out form_____Relationship_____

Parent/Gaurdian information

Mothers Name_____Date of Birth_____

Cell Phone #_____Home #_____Work#_____

Home Address_____

City_____State_____Zip Code_____

Email address_____Social Security #_____

Father's Name_____Date of Birth_____

Cell Phone#_____Work #_____

Home Address_____

City_____State_____Zip Code_____

Email Address_____Social Securtiy #_____

Emergency Contact (relative or friend)_____Phone #_____

Insurance Information (PERSON that HOLDS the CARD)

Primary Insurance_____ ID #_____

Group #_____SUBSCRIBER Name_____DOB_____

Patient relationship to subscriber_____Employer_____

Employer's Address_____

Employer's Phone #_____

Secondary Insurance _____ID #_____

Group #_____Subscriber's Name_____DOB_____

Social Security #_____Pt's relationship to subscriber_____

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, I also authorize Fort Washington Park Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian Signature_____Date_____

Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Today's Date	Relationship:

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

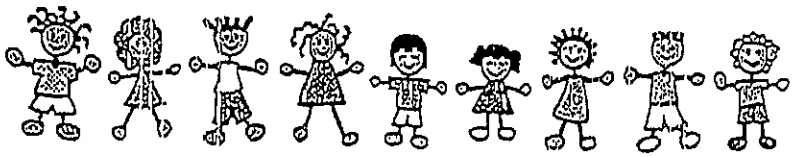
MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:



Fort Washington Park Pediatrics, P.C.
11701 Livingston Road, Suite 202
Fort Washington, MD. 20744
Phone (301)292-7400 Fax (301)292-7062

CONSENT FOR TREATMENT OF A MINOR

I, _____, The parent or guardian of _____, who is a minor, authorize Fort Washington Park Pediatrics, P.C. and all persons acting as agents thereof and all physicians to whom said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to Fort Washington Park Pediatrics, P.C.

AUTHORIZATION AND RELEASE

I authorize Fort Washington Park Pediatrics, P.C. To release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Fort Washington Park Pediatrics, P.C., insurance benefits otherwise payable to me.

PAYMENT POLICY

I understand that if Fort Washington Park Pediatrics, P.C./Edwin Aguilar, M.D. is not contracted with my insurance carrier, I must pay in full at the time of service. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that some services provided by Fort Washington Park Pediatrics, P.C. may not be covered by my benefit plan. I agree to be responsible for payment of all services rendered. I understand that any balance generated is due within 10 days of the billing day, unless other arrangements are made. I realize that failure to keep this account current may result in Fort Washington Park Pediatrics, P.C. no longer being able to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

NEW BABY

I fully understand that my newborn baby needs to be added to my insurance policy by the two week appointment. If my newborn baby has not been added to the policy or does not have health insurance, I am aware that I am responsible for the office fee at the time services are rendered.

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM, NAMELY THE SECTIONS TITLED CONSENT TO TREATMENT OF A MINOR, AUTHORIZATION AND RELEASE AND PAYMENT POLICY. I AM THE PARENT OF SAID MINOR CHILD, OR THE COURT APPOINTED GUARDIAN FOR THE PATIENT AND I AM AUTHORIZED TO ACT ON THE PATIENT'S BEHALF TO SIGN THIS RELEASE OF INFORMATION.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

FORT WASHINGTON PARK PEDIATRICS, P.C.
11701 Livingston Road, 202
Fort Washington, MD. 20744
Phone (301)292-7400 Fax (301)292-7062

WELCOME TO FORT WASHINGTON PARK PEDIATRICS

Patient's Name:_____Date of Birth:_____

In order to serve you better at your first appointment, we ask you to complete the following before we can make your first appointment.

If your child has any health issues, please request a copy of the records from the previous pediatrician and any specialist he/she is seeing so that doctors can review them to decide if our office will be the best option for your child. The front desk has a release form. PLEASE NOTE THAT IT IS YOUR RESPONSIBILITY TO GET THE RECORDS.

Please provide a copy of the shot record from the previous doctor's office. If you need to send a request, ask the front desk for a release form. PLEASE NOTE THAT IT IS YOUR RESPONSIBLITTY TO GET THE RECORDS.

Call and change the PCP (Primary Care Physician) to Dr. Edwin Aguilar. (Note if you have Priority Partners or JAI – WE CANNOT SEE A PATIENT UNTIL YOU HAVE A CARD WITH DR. EDWIN AGUILAR'S NAME ON IT. NO EXCEPTIONS)

We only accept patients who accept the American Academy of Pediatrics vaccine schedule and do not see anyone that refuses vaccines. I understand and accept the American Academy of Pediatrics Vaccine Schedule

_____ (please initial)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I understand that this information can and will be used to:

-Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly,
-Obtain payment from third-party payers,
-Conduct normal healthcare operations such as, quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information. I understand that Fort Washington Park Pediatrics, P.C. has the right to change its notice of Privacy Practice from time to time and that I may contact Fort Washington Park Pediatrics, P.C. at any time in writing at the address above to obtain a current copy of the Notice Of Privacy Practices.

I understand that I may request, in writing, how my private information is used, or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions. If it is not feasible for FWPP to ensure compliance or believe it will negatively impact the care Fort Washington Park Pediatrics provides.

Signature _____ Relationship:_____

Date:_____(If patient is under 18 years old, parent or legal guardian signature is required)

Fort Washington Park Pediatrics
11701 Livingston Road #202
Fort Washington, MD. 20744
301-292-7400

Our office is now able to send your prescriptions directly to your pharmacy! In order for the doctor to send them, we need to know your preferred pharmacy.
If you would rather have the doctor print your prescriptions out, please inform the nurse before the doctor sees you. Thank You!

Pharmacy
Name: _____

Pharmacy
Address: _____