Baltimore Medical System
THE HEART OF COMMUNITY HEALTH

Pediatric Patient History Update

Name: _____

History Number: _____

Date of Birth: _____

Date of Service: _____

DIRECTIONS: PLEASE FILL IN THIS FORM AS WELL AS YOU CAN. SKIP OVER ANY QUESTIONS WHICH ARE DIFFICULT FOR YOU. YOUR PHYSICIAN, PRACTITIONER, OR NURSE WILL HELP YOU WITH THEM. (PLEASE PRINT IN BLACK OR BLUE INK)

List current health problems (including behavior & mental health issues):

_____
_____
_____
_____

List current medications and doses (include vitamins & herbal remedies):

_____
_____
_____
_____

ALLERGIES - Please list any medicines or substances to which the patient is allergic:

_____
_____

HOSPITALIZATIONS / INJURIES:

Please list any operations, hospital admissions, or serious accidents/injuries your child has had. If you've completed this form before, please provide us with an update with any problems in the last three years.

OPERATION, HOSPITALIZATION, or ACCIDENT	DATE (month/year)	HOSPITAL

HOUSEHOLD INFORMATION

Lives With (circle): Both Parents / Mom Primarily / Dad Primarily

Other (please specify): _____

Sibling Names/DOB: _____

_____

_____

Parents' Status (circle): Married / Divorced / Separated / Other

Father's Name: _____

Father's Employment: _____

_____

Mother's Name: _____

Mother's Employment: _____

_____

SAFETY AND ENVIRONMENTAL EXPOSURES

Exposure to Tobacco Smoke: □ Yes □ No

Smoke Exposure Location: □ Inside □ Outside □ Both

Pets: □ Yes □ No

Mold/Mildew: □ Yes □ No

Lead Paint: □ Yes □ No

Who Smokes: _____

_____

Guns in the House: □ Yes □ No

Carpets: □ Yes □ No

Pests/Rodents: □ Yes □ No

BIRTH HISTORY:

Please complete for patients currently under one year of age.

Birth Length: _____

Birth Weight: _____

Birth Head Circ.: _____

Discharge Weight: _____

Gestational Age: _____

Delivery Method: Vaginal / C-Section

Duration of Labor: _____

Hospital Name: _____

APGAR Score (1 min): _____

APGAR Score (5 min): _____

Feeding (circle one): Breast / Formula

DAY CARE / EDUCATION / EMPLOYMENT

Type of Day Care (check all that apply):

□ Family Member/Relative/Friend

□ Child Care Center (commercial)

□ Home Child Care Provider (day care run from someone's home)

□ Head Start

□ Preschool

□ Prekindergarten

Patient Name: _____ **Date of Birth:** _____

VACCINATIONS

Are vaccines up to date? □ Yes □ No Do you have the records with you today? □ Yes □ No

MEDICAL HISTORY

ADD/ADHD	□ Yes	□ No	Headaches/Other	□ Yes	□ No	Scoliosis	□ Yes	□ No
Allergies	□ Yes	□ No	Hearing Loss	□ Yes	□ No	Seizures	□ Yes	□ No
Asthma	□ Yes	□ No	Hearing Problems	□ Yes	□ No	Sickle Cell Anemia	□ Yes	□ No
Behavioral Problems	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Speech Delay	□ Yes	□ No
Cancer	□ Yes	□ No	Jaundice	□ Yes	□ No	Strep Throat (recurrent)	□ Yes	□ No
Chronic Encephalopathy	□ Yes	□ No	Lead Poisoning	□ Yes	□ No	UTI	□ Yes	□ No
Developmental Delay	□ Yes	□ No	Meningitis	□ Yes	□ No	Varicella (chicken pox)	□ Yes	□ No
Diabetes Mellitus	□ Yes	□ No	Obesity	□ Yes	□ No	Vision Problems	□ Yes	□ No
Eczema	□ Yes	□ No	Otitis Media	□ Yes	□ No	Other: _____		
Headaches/Migraines	□ Yes	□ No	Pneumonia	□ Yes	□ No	Other: _____		

SURGICAL HISTORY

Adenoidectomy	□ Yes	□ No	Ear Tubes	□ Yes	□ No	Lymph Node Biopsy	□ Yes	□ No
Appendectomy	□ Yes	□ No	Gastrostomy	□ Yes	□ No	Tonsillectomy	□ Yes	□ No
Cleft Lip	□ Yes	□ No	Heart Surgery	□ Yes	□ No	Umbilical Hernia	□ Yes	□ No
Cleft Palate	□ Yes	□ No	Inguinal Hernia	□ Yes	□ No	VP Shunt	□ Yes	□ No

Other: _____

PHARMACY

What is your preferred pharmacy (please be specific)?

Name (CVS, RiteAid, etc.): _____ Store Number (if known): _____

Address: _____ City: _____ State: _____

FAMILY HISTORY: Please check the appropriate box(es)

RELATIONSHIP	Alcohol / Drug Abuse	Anemia / Blood Disease	Asthma	Birth Defect	Cancer	Coronary Artery Disease	Depression	Diabetes	Early Death	Hearing Loss	HIV	High Cholesterol / Hyperlipidemia	High Blood Pressure / Hypertension	Kidney Disease	Learning Disability	Mental Illness	Seizures/Convulsions	Stroke	Vision Problems	Heart Attack	Allergies	Eczema	Other
Mother																							
Father																							
Sister																							
Brother																							
Maternal Grandmother																							
Maternal Grandfather																							
Paternal Grandmother																							
Paternal Grandfather																							
Other: _____																							
Other: _____																							

Baltimore Medical System
THE HEART OF COMMUNITY HEALTH

Place Patient Label Here

PREVENTIVE MEDICINE SCREENING QUESTIONNAIRE		
Lead Risk Questionnaire (ages 6 months to 6 years)	YES	NO
1. Does your child live in or regularly visit a house with peeling, flaking, chipping paint built before 1978? Including but not limited to home, daycare, or relative?		
2. Does your child live in or regularly visit a house built before 1978, with recent, ongoing or planned renovations?		
3. Does your child have a brother or sister, a housemate, or playmate being followed or treated for lead poisoning?		
4. Does your child eat or lick non-edible objects, such as dirt, wood, railings?		
5. Does your child live with someone whose job or hobby involves exposure to lead?		
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?		
Tuberculosis Risk Assessment (ages 1 month through 21 years)		
1. Was your child born in a high risk country ? (countries other than U.S., Canada, Australia, New Zealand or Western and North European countries) If yes, what country and year.		
2. Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?		
3. Has your child had a family member or contact with tuberculosis disease?		
4. Has your child had a family member with a positive tuberculin skin test result (PPD)?		
Heart Disease/Cholesterol Risk Assessment (ages 2 through 21 years)		
1. Is there family history of Parent/Grandparent under the age of 55 who underwent a study of the heart blood vessels and were found to have hardening of the arteries? This includes Parent/Grandparent that have undergone balloon heart procedure of bypass surgery.		
2. Is there a family history of Parent/Grandparent under the age of 55 who have suffered a heart attack, a stroke, or have angina, or blood vessel disease?		
3. Does either Parent have high blood cholesterol (240 mg/dl or higher)?		
4. Does the patient (teen/child) have a history of:		
Smoking?		
Lack of physical activity?		
High blood pressure?		
High cholesterol?		
Obesity/overweight?		
Diabetes?		
Mental Health Screening		
1. Have you or your child been the victim of violence or abuse (hit, slapped, hurt)?		
2. Is there a recent stress on the family or child such as birth of a child, moving, divorce or separation, death of a close relative?		

STD/HIV Risk Assessment (ages 12 through 20 years)		
1. Has the patient had a blood transfusion or is he/she currently diagnosed with Hemophilia?		
2. Has the patient ever been diagnosed with any sexually transmitted diseases? (gonorrhea, syphilis, venereal warts, chlamydia, herpes)		
3. Has the patient ever been sexually molested or physically attacked?		
4. Any history of IV drug use by patient, patient's sex partner or patient's birth mother during pregnancy?		
5. If sexually active, has the patient had unprotected sex with opposite/same sex partner?		
6. If sexually active, has the patient had more than one sex partner?		
7. Does the patient have any tattoos or body piercings including any performed by friends?		

Baltimore Medical System
THE HEART OF COMMUNITY HEALTH

Baltimore Medical System
Registration Form

PATIENT INFORMATION

Patient's Name: _____
(FIRST) (MIDDLE) (LAST)

For minor patient:

Mothers Name: _____ **Fathers Name:** _____ **Guardian Name:** _____

Social Security Number: _____ **Date of Birth:** _____ **Sex:** _____

Address: _____ **City:** _____ **State:**_____ **Zip Code:**_____

E-MAIL Address:_____

Home Phone Number: _____ **Cell Phone Number:** _____ **Work Phone:** _____

Emergency Contact Name: _____ **Emergency Contact Number:** _____

Race - Check all that apply:

□ **White** □ **Black or African American** □ **American Indian or Alaska Native** □ **Asian** □ **Other Pacific Islander** □ **Native Hawaiian** □ **Other:**_____

Ethnicity: (Check Yes or No) Hispanic or Latino: □ YES □ NO

GENERAL CONSENT

CONSENT TO TREATMENT

I wish to receive health care services from Baltimore Medical System (BMS). I understand that BMS physicians, nurses **and other health care providers who will be caring for me may determine that certain tests or treatments are necessary in** order to care for me. I consent to those tests and treatments that my physician or his or her assistant determine are necessary or appropriate for my care.

AUTHORIZATION TO RELEASE OR USE HEALTHCARE INFORMATION

I authorize BMS to use and disclose my health information, information about the care I receive, and my medical records:

- To other health care providers who will be involved in my care,
- As necessary to receive payment for the services BMS provides to me for BMS' healthcare operations
- For other purposes described in BMS Notice of Privacy Practices that has been given to me.

AUTHORIZATION TO PAY BENEFITS

I request that payment of authorized benefits be made on my behalf.

OPPORTUNITY TO ASK QUESTIONS

I have had an opportunity to ask questions about this General Consent and those questions have been answered to my satisfaction.

HIPAA PRIVACY PRACTICES RECEIPT FORM

HIPAA PRIVACY PRACTICES RECEIPT

I certify that I have received from Baltimore Medical System (BMS) the Notice of Privacy Practices (NPP) describing how BMS may use and disclose my Protected Health Information (PHI) to carry out health treatment, payment or health care operations and for other purposes that are permitted or required by law. I also understand that the NPP describes my rights to access and control my protected health information. In addition, I hereby authorize the release of information to personal acquaintances named below (and relationship if possible):

1. _____ Relationship: _____

2. _____ Relationship: _____

X Patient: _____ Witness: _____ Date:_____
Signature of Patient or Person Authorized to Consent to Health Care for Patient

Name: _____ Relationship if signed by other than patient: _____

Baltimore Medical System
THE HEART OF COMMUNITY HEALTH

NAMING ANOTHER PERSON
TO MAKE HEALTH CARE DECISIONS FOR A CHILD (3rd Party Consent)

WHAT DOES THIS FORM DO? It lets you name a person to bring the child to the doctor and to agree to let the child get healthcare services like a doctor visit, shots, or care for the flu.

WHO CAN SIGN THIS FORM? The child's parent or a court-appointed custodian.

Child's Name: _____

Your Name: _____

1. I am the child's [_] parent, [_] court-appointed representative **[CHECK ONE]**

2. I authorize the following person to agree to routine and follow-up healthcare for the child.

   Name : _____

   Address (include apartment number): _____

   _____

   City, State, Zip Code: _____, _____ _____

   Telephone number - home (_____) _____- _____

   Telephone number - work (_____) _____- _____

   Relationship to the child (for example, grandmother, cousin, neighbor)

   _____

3. I know the person I named in "2" above will be able to consent to healthcare for the child **unless** I tell BMS something else in writing,

_____
Your Signature

NOTICE OF PRIVACY PRACTICES

Baltimore Medical System
THE HEART OF COMMUNITY HEALTH

Privacy Officer
Baltimore Medical System
3501 Sinclair Lane
Baltimore, MD 21213
410-732-8800

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information . **Please review it carefully.**

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities.

Your Rights

- **Get a copy of your health and claims records:**
  -You can ask to see or obtain an electronic or paper copy of your medical records. Ask us how to do this.
  -We will provide a copy or a summary of your health information, usually within 14 days of your request.
  -We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record:**
  -You can ask us to correct your health information about you that you think is incorrect or incomplete. Ask us how to do this.
  -We may say "no" to your request, but we'll tell you why in writing within 60 days of your request.
- **Request confidential communication:**
  -You can ask us to contact you in a specific way (such as, home or office phone) or to send mail to a different address.
  -We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit the information we share**
  -You can ask us not to use or share certain health information for treatment, payment, or our operations.
  -We are not required to agree to your request, and we may say "no" if it would affect your care.
  -We have chosen to participate in the Chesapeake Regional Information System for our patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provider faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.
- **Get a list of those with whom we've shared your information:**
  -You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
  -We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice:**
  -You can ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.
- **Choose someone to act for you:**
  -If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  -We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you believe your privacy rights have been violated:**
  -You can complain if you feel we have violated your rights by contacting us using the information on page 1.
  -You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
  -We will not retaliate against you for filing a complaint.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available on our web site. Upon request, we will give or mail a copy to you.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  -Share information with your family, close friends, or others involved in payment for your care
  -Share information in a disaster relief situation
  -Contact you for fundraising efforts
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- *In these cases we never share your information unless you give us written permission:*
  -Marketing purposes
  -Sale of your information
  -Most sharing of psychotherapy notes
- In the case of fundraising:
  -We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you:**
  -We can use your health information and share it with professionals who are treating you.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services
- **Run our organization:**
  -We can use and share your information to run our organization, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.
- Bill **for your health services:**
  - We can use and disclose your health information as we pay for your health services.
  Example: We share information about you with your dental plan to coordinate payment for your dental work.

How else can we use or share your health information? We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

- **Help with public health and safety issues:**
  -We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- **Do research**
  -We can use or share your information for health research.
- **Comply with the law**
  -We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director-**
  -We can share health information about you with organ procurement organizations.
  -We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**
  -We can use or share health information about you:
    - **For workers' compensation claims**
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective service
- **Respond to lawsuits and legal actions**
  -We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Baltimore Medical System Patient Rights and Responsibilities

Baltimore Medical System is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- Choose/Change your own Baltimore Medical System Physician and/or Pharmacy.
- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that Baltimore Medical System will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the health center's rules about patient conduct; for example, there is no smoking in any Baltimore Medical System health center.
- Respecting the rights and property of Baltimore Medical System and its employees and other persons in the health center.