Forest Hill Pediatrics, LLC

Grace Kobusingye, M.D., F.A.A.P.
2005 Rock Spring Road, Suite 1
Forest Hill, MD 21050

<u>Confidential Patient Information</u>: Today's Date: _____/_____/_____

Patient Name: ____

Address:____
Street City State Zip

Birth date: _____/_____/_____ Known Allergies: ___________________________________

Mother's Name: ____

Father's Name: ____

Telephone # (home): ___________________________ (work): ___________________________

(cell): ___________________________

Daycare Provider Name & Telephone #: _____________________________________

Person authorized by you to seek medical care in care of emergency:

Name: ____ Telephone #: ______________________________

Who referred you to our practice? ____

<u>Billing Information</u>:

Primary Insurance Company: ____ ID#: ________________

Policy Holder/Responsible Party /Guarantor: ____

Policy Holder/Responsible Party/Guarantor Date of Birth: _____/_____/_____

Employer/Group Name: ____ Group #: _____________________

Co-pay: $ _____.00 Prescription Plan? ☐ Y or ☐ N

Secondary Insurance Company: ____ ID#: ________________

I authorize the release of health information for the above named patient to process claims.

(Signature): ____

I authorize payment of medical benefits to the physician for services rendered.

(Signature): ____

Your insurance company may not necessarily cover all of your healthcare costs. If you need a service that is not a covered item under the insurance contract, you will be responsible for the service.

(Signature): ____

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Medical/Family History Questionnaire

Patient Name:		Date of Birth:
Form Completed By:	Today's Date:	Relationship:

PREGNANCY AND BIRTH HISTORY

Name of Hospital:
Illnesses during pregnancy?
Medications during pregnancy?
Alcohol/Drug Abuse
Problems at birth?
Describe:
Type of delivery? Vaginal ☐ C-section ☐
Birth Weight Discharge Weight
Did baby receive Hepatitis B Vaccine? No ☐
Date of Hepatitis B immunization: / /

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? ________________________________
Other languages? ____________________________

FAMILY HISTORY

Has anyone in the family (parent, grandparents, aunts/uncles, sisters/brothers) had:

	No	Yes	Who?
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 ☐	_______
Allergies/Asthma	No ☐	Yes ☐	_______
Mental Illness	No ☐	Yes ☐	_______
Cancer	No ☐	Yes ☐	_______
Birth Defects	No ☐	Yes ☐	_______
Hearing/Speech Problems	No ☐	Yes ☐	_______
Kidney Disease	No ☐	Yes ☐	_______
Alcohol/Drug Abuse	No ☐	Yes ☐	_______
Hepatitis/liver Disease	No ☐	Yes ☐	_______
Thyroid Disease	No ☐	Yes ☐	_______
Learning Problems/Attention	No ☐	Yes ☐	_______
Deficit Disorder	No ☐	Yes ☐	_______
Family Violence	No ☐	Yes ☐	_______

Other: ___________________________________

HEALTH HISTORY

Has your child ever had:

	No	Yes
Chicken Pox (Year)	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
Asthma/Allergies	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 Infection	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually transmitted Diseases	No ☐	Yes ☐
emotional or Behavioral Problem	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: ______________________
Current Medication(s): ______________________

Reviewed by:	Date of Review:

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Preventive Medicine Screening Questionnaire

Tuberculosis Risk Assessment	**Yes**	**No**
1. Was your child born in, or lived more than a year in a country OTHER THAN THE USA? Which country: Which year:		
2. Has your child been exposed to anyone with either Tuberculosis or a history of Tuberculosis Disease?		
3. Is your child currently living in a household with anyone who is HIV positive?		
4. Is your child part of a migrant worker family?		
Lead Risk Questionnaire (ages 6 months to 6 years)		
1. Does your child currently live, or has 1te/she ever lived in a house or apartment built before 1960(includes day care center, preschool home, home of baby-sitter or relative)?		
2. Is anyone in the home being treated 0 followed for lead poisoning?		
3. Are there any current renovations or I' ee1ing paint in a home that your child regularly visits?		
4. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter etc)?		
Heart Disease/Cholesterol Risk Assessment (Ages 2 through 21 years)		
1. Is there a FAMILY HISTORY OF PARENT/GRANDPARENTS under the ages of 55 who underwent a study of the heart blood vessels and were found to have hardening of the arteries? This includes parents and grandparents who have undergone balloon heart procedures or heart bypass surgery.		
2. Is there a FAMILY HISTORY OF PARENTS/GRANDPARENTS under the age of 55 who have suffered a heart attack, a stroke or who have angina or blood vessel disease.		
3. Does either PARENT have a high blood cholesterol (240 mg/dl or higher)		
4. Does the patient (TEEN/CHILD) have a history of:		
Smoking		
Lack of physical activity		
High cholesterol		
Obesity/overweight		
Diabetes		
For physician/nurse practitioner/physicians assistant use only		
Parental or Grandparent history is unobtainable		
☐ Cholesterol drawn Previous cholesterol		
☐ Healthy lifestyle discussed		

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Forest Hill, Maryland 21050

Authorization to Treat

Date: _____/_____/_____

We designate ____ (guardian/family member) to seek medical care for our child(ren) in our absence.

Children name(s) and date(s) of birth:

____ date of birth / /

____ date of birth / /

____ date of birth / /

____ date of birth / /

This authorization is valid from (dates)
/ / to / /

Medical Insurance Company ____

Policy Number: ____________________________

Parent/Guardian Signature: ____

Thank you.

Forest Hill Pediatrics, LLC
Dr. Grace Kobusingye
2005 Rock Spring Road, Suite 1
Forest Hill, MD 21050

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN IACKNOWLEDGEMENT FORM

Patient Name: ____

I, (Name of Patient or Legal Guardian)_____, have read and understand the copy of Forest Hill Pediatrics, LLC's Notice of Privacy Practices.

____ _______________
(Signature of Patient or Legal Guardian) (Date Signed)