CHESAPEAKE PEDIATRICS, LLC

PATIENT INFORMATION

FATHER'S INFORMATION

LAST NAME	FIRST NAME				BIRTHDATE
HOME ADDRESS	STREET	APT#			
CITY	STATE	ZIP CODE			(AREA CODE) PHONE#
EMPLOYER					
BUSINESS ADDRESS	STREET	CITY	STATE	ZIP CODE	PHONE #

MOTHER'S INFORMATION

LAST NAME	FIRST NAME				BIRTHDATE
HOME ADDRESS	STREET	APT#			
CITY	STATE	ZIP CODE			(AREA CODE) PHONE#
EMPLOYER					
BUSINESS ADDRESS	STREET	CITY	STATE	ZIP CODE	PHONE #

CHILDREN

LAST NAME	**FIRST NAME**	**BIRTHDATE**	**MALE/FEMALE**
LAST NAME	**FIRST NAME**	**BIRTHDATE**	**MALE/FEMALE**
LAST NAME	**FIRST NAME**	**BIRTHDATE**	**MALE/FEMALE**
LAST NAME	**FIRST NAME**	**BIRTHDATE**	**MALE/FEMALE**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME

COMPANY ADDRESS
POLICY HOLDER'S NAME
POLICY NUMBER

OTHER INFORMATION

PREVIOUS PEDIATRICIAN OR PHYSICIAN_____

WHO REFERRED YOU TO OUR OFFICE?_____

DO YOUR CHILDREN HAVE A
DENTIST?_____

FAMILY HISTORY

HAVE GRANDPARENTS, PARENTS, OR SIBLINGS HAD ANY OF THE FOLLOWING:

DIABETES HYPERTENSION CANCER ALLERGIES ANEMIA

HEART DISEASE THYROID DISEASE SEIZURES SICKLE CELL

HIGH CHOLESTEROL AUTOIMMUNE DISORDERS OTHER_____

DOES ANYONE IN THE FAMILY SMOKE? YES NO
DOES ANYONE HAVE A DRUG PROBLEM? YES NO
DOES ANYONE HAVE AN ALCOHOL PROBLEM? YES NO

DOES YOUR HOME HAVE SMOKE ALARMS? YES NO
DOES EVERYONE USE A SEATBELT? YES NO
DOES EVERYONE USE A BIKE HELMET? YES NO

DO YOU LIVE IN AN OLDER HOME (BEFORE 1960) YES NO WHICH MAY HAVE LEAD BASED PAINT

IS YOUR RESIDENTIAL WATER SOURCE/SUPPLY WELL OR CITY? _____

MISCELLANEOUS

FATHER/GUARDIAN/STEP FATHER'S **OCCUPATION** _____
EDUCATION _____

MOTHER/GUARDIAN/STEP MOTHER'S **OCCUPATION** _____
EDUCATION _____

WHO LIVES IN THE HOUSE?

NAME	**RELATIONSHIP**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

CHESAPEAKEPEDIATRICS

121OLDSOLOMONSISLANDRD•ANNAPOLIS,MD•21401
PHONE:410-224-3663•FAX:410-224-2693

CHESAPEAKE PEDIATRICS

PATIENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, realize that I am financially responsible for all services rendered to me by **Chesapeake Pediatrics, LLC.**

For those insurance for which **Chesapeake Pediatrics LLC**, accepts assignment, I realize that I am personally responsible for all co-payments, deductibles, and non-covered services, as dictated by my insurance company.

I authorize **Chesapeake Pediatrics LLC**, to release to my insurance carrier(s)/employer/ attorney and any medical information necessary to obtain reimbursement, including mental health and substance abuse information.

Without expressed revocation this consent is valid until revoked in writing by me, the parent or legal guardian.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Parent/Legal Guardian Date

I,_____,(parent/legalguardian)of_____,_____ _____,_____,give permission for the following to bring said children to your office for medical treatment.

Name/Relationship Telephone Number

1.
2.
3.
4.

_____ _____

Parent/Legal Guardian Date

CHESAPEAKE PEDIATRICS LLC

121 OLD SOLOMONS ANNAPOLIS, MD 21401

410-224-3663