Patient Information Form

Patient Name: ________________________________ Patient DOB: ______________

Parent/Guardian Name: __________________________ Appointment Date: __________

Address: ____
Street Address *Apt/Floor* *City* *State* *Zip*

Preferred Phone: ______________________________ ○ Home ○ Work ○ Cell

May we leave voice mail messages on this number? ○ Yes ○ No

Parent/Guardian Email: ____

May we email you with appointment reminders and wellness information? ○ Yes ○ No

Reason for Today's Visit: ____

Pediatrician/Primary Care Provider Name: ______________________________________

Primary Insurance: ____

Preferred Pharmacy: ____

Patient Health History

Patient Name: ____ Patient DOB: __________________

Form Completed by: ____ Today's Date: __________________

Family Medical History

Have any family members had (or do any currently have) any of the following conditions? *Please write the relationship of affected family members to the patient on the line, e.g.: maternal grandmother*

High blood pressure: ○ No ○ Yes: ______________________________

High cholesterol: ○ No ○ Yes: ______________________________

Mental health issues: ○ No ○ Yes: ______________________________

Heart attack/stroke before 50: ○ No ○ Yes: ______________________________

Diabetes: ○ No ○ Yes: ______________________________

Thyroid problems: ○ No ○ Yes: ______________________________

Overweight or obese: ○ No ○ Yes: ______________________________

Mother's height: ____________ Mother's weight: ___________ Age at first menstrual period: ____________

Father's height: ____________ Father's weight: ___________ Puberty: ○ Early ○ Average ○ Late

Please list child's siblings *(including half-siblings as well as any no longer living and cause of death)*, with sex, age, and any information on size and age at onset of puberty: ______________________________

____

____

Child's Birth History

Child's weight at birth: ______________________________ Child's length at birth: ____________________________
lbs. oz. inches

Was the child born within 2 weeks of due date? ○ Yes ○ No (how many weeks early? ________________)

Did the child's mother experience any of the following during pregnancy?

Medications taken: ○ No ○ Yes (*please specify*): ____

Tobacco use: ○ No ○ Yes Alcohol use: ○ No ○ Yes

Gestational diabetes: ○ No ○ Yes 35+ lbs. weight gain: ○ No ○ Yes

Was the child:

Breast-fed, bottle-fed, or both? ○ Breast ○ Bottle ○ Both

Introduced to solid food before 4 months? ○ Yes ○ No

Any problems in the newborn period? ○ Jaundice ○ Feeding ○ Breathing ○ Infection

○ Other: ____

Child's Developmental History

At what age did the child first:

Stand independently? _______________ Walk? ______________ Speak more than 3 words? __________________

Has there ever been a concern about a delay in your child's development? ○ No ○ Yes

If yes, please explain: ____

What grade is the child in currently? _________ Is the child having any problems in school? ○ No ○ Yes

If yes, please describe the problems: ____

____

Does your child attend any special classes for any reason? ○ No ○ Yes *(list reason)*_______________________

____

Child's Medical History

Has the child had (or does he/she currently have) any of the following conditions?

ADD/ADHD:	○ Yes ○ No	Heart murmur:	○ Yes ○ No
Asthma:	○ Yes ○ No	High blood pressure:	○ Yes ○ No
Broken bone/stress fracture:	○ Yes ○ No	High cholesterol:	○ Yes ○ No
Chronic constipation:	○ Yes ○ No	Diabetes:	○ Yes ○ No
Overweight or obese:	○ Yes ○ No	Head injury:	○ Yes ○ No
Thyroid problems:	○ Yes ○ No		

Has the child ever experienced *(with or without exercise):* ○ Chest pain ○ Fainting ○ Shortness of breath

Does the child have any allergies to medication? ○ No ○ Yes *(please list)* ________________________________

____

Does the child have any allergies to foods? ○ No ○ Yes *(please list)* ________________________________

____

Does the child have any allergies to anything else? ○ No ○ Yes *(please list)* ____________________________

____

Has the child ever been hospitalized? ○ No ○ Yes (*please provide ages and reasons*): ________________

____

Has the child ever had surgery? ○ No ○ Yes (*please provide ages and reasons*): ______________________

____

Is the child on any medications? ○ No ○ Yes (*please list medication name, year started, and dosage*):

____

____

Child's Systems Review

If you answer yes to any question, please describe and provide the duration for each complaint in the space provided. Additional space is available at the end of this section.

GENERAL:

Has there been recent weight gain or loss? ○ No ○ Yes ____________________________________

Is the child unusually tired or sluggish? ○ No ○ Yes ______________________________________

Have there been frequent fevers/chills/loss of appetite? ○ No ○ Yes ___________________________

EYES:

Has the child had trouble seeing lately (e.g. sits very close to TV)? ○ No ○ Yes ___________________________

Has the child mentioned blurred vision or double vision? ○ No ○ Yes ___________________________________

EARS, NOSE & THROAT:

Has the child had frequent ear infections? ○ No ○ Yes ____

Are there any problems with hearing? ○ No ○ Yes ____

Is there ongoing nasal congestion or nosebleeds? ○ No ○ Yes ____

Does the child snore loudly at night? ○ No ○ Yes ____

Does the child have difficulty swallowing? ○ No ○ Yes ____

CHEST:

Has the child ever had chest pain? ○ No ○ Yes ____

Has the child had a frequent cough? ○ No ○ Yes ____

Does the child get short of breath or tire very easily with exercise? ○ No ○ Yes __________________________

Does the child complain of his/her heart beating rapidly when at rest? ○ No ○ Yes _______________________

Has the child ever passed out? ○ No ○ Yes ____

Has a doctor ever ordered a heart test (ECG/EKG, echocardiogram)? ○ No ○ Yes _________________________

ABDOMEN:

Does the child have frequent loose bowel movements? ○ No ○ Yes ____________________________________

Does the child have frequent constipation? ○ No ○ Yes ____

Does the child have bloody or very dark bowel movements? ○ No ○ Yes ________________________________

Are there frequent stomach pains which come and go? ○ No ○ Yes ____________________________________

Is there frequent vomiting or nausea? ○ No ○ Yes ____

URINARY TRACT:

Has there been frequent bedwetting? ○ No ○ Yes ____

Is there pain or burning with urination? ○ No ○ Yes ____

Has there been any visible blood in the urine? ○ No ○ Yes ____

SKIN & HAIR:

Does the child have a skin rash? ○ No ○ Yes ____

Has there been any change in skin color? ○ No ○ Yes ____

Is the child's hair thinning or falling out more than usual? ○ No ○ Yes ___________________________________

BONES, JOINTS & MUSCLES:

Does the child have painful, stiff or swollen joints? ○ No ○ Yes ___________________________

Has there been a decrease in muscle strength? ○ No ○ Yes ___________________________

NEUROLOGICAL:

Does the child have frequent headaches? ○ No ○ Yes ___________________________

Has your child ever had a seizure? ○ No ○ Yes ___________________________

ENDOCRINE:

Does your child feel cold or hot all the time? ○ No ○ Yes ___________________________

Is there any unwanted hair growth on the face/chest/back? ○ No ○ Yes ___________________________

Does the child urinate frequently? ○ No ○ Yes ___________________________

Does the child drink more fluids than is typical? ○ No ○ Yes ___________________________

MENTAL WELLBEING:

Does the child experience anxiety? ○ No ○ Yes ___________________________

Does the child experience depressive moods? ○ No ○ Yes ___________________________

Does the child experience panic attacks? ○ No ○ Yes ___________________________

Does the child have difficulty concentrating? ○ No ○ Yes ___________________________

Is (was) the child being seen by a mental health professional? ○ No ○ Yes ___________________________

REPRODUCTIVE (GIRLS ONLY):

Has there been any blood or discharge from vagina? ○ No ○ Yes ___________________________

Has she had her first period? If so, at what age? ○ No ○ Yes ___________________________

Are her periods irregular or very painful? ○ No ○ Yes ___________________________

Is there any discharge or fluid from breasts? ○ No ○ Yes ___________________________

ADDITIONAL NOTES ON ANY CONDITION ABOVE, AND/OR OTHER MEDICAL CONCERNS: ___________________________

____

____

____

Child's Lifestyle

NUTRITION:

How many days a week does the child:

Eat breakfast? __________ Eat lunch? __________ Buy school lunch? __________

Eat at a restaurant or eat takeout food? _________ Eat a meal in front of the TV/computer? __________

How many days a week does the family eat dinner together at home? _______________

How many servings *(about 1 cup)* of fruit does the child eat each day? ______________________

How many servings *(about 1 cup)* of vegetables does the child eat each day? ________________

How many 8-ounce *(1 cup)* servings of the following beverages does the child drink each day?

Soda/sweet tea: __________ *Juice:* __________ *Whole milk:* __________ *Water:* __________

2%, 1% or skim milk: _______ *Sports drinks:* _______

Please list your child's favorite food/beverages: ____

____

Please list foods your child avoids or dislikes: ____

____

PHYSICAL ACTIVITY:

How many hours per day does the child spend being active (e.g. walking, running, biking, playing a sport, dancing, going to the playground or playing outside)?

Less than 15 minutes *15 minutes* *30 minutes* *60 minutes* *More than 60 minutes*

How much recreational screen time – outside of schoolwork – does the child have each day (including TV, computer, video games, phone, tablet)?

Less than 1 hour *1 hour* *2 hours* *3 hours* *4 hours* *5 hours* *More than 5 hours*

Please list the child's favorite activities: ____

____

SLEEP:

How many hours does the child usually sleep each night?

Fewer than 6 *6* *7* *8* *9* *10* *11* *12* *More than 12*

Is there a television or computer in the child's bedroom? ○ Yes ○ No

Does the child use a tablet, phone or play video games in his/her room before bedtime? ○ Yes ○ No

GENERAL PATIENT/FAMILY CONCERNS:

Are you concerned today about the child's health and wellness? ○ Yes ○ No

Do you feel changes in eating, activity and/or sleep patterns could improve his/her health? ○ Yes ○ No

What specific changes would you like to discuss with Dr. Parker at today's visit? Circle the 3 most important:

Eating more fruits and vegetables *Drinking fewer sugary beverages* *Drinking more water*

Eating healthier snacks *Ideas for healthier meals* *Not skipping meals*

Increasing physical activity *Setting goals for screen time* *Getting more sleep*

Are there any other lifestyle-related issues or concerns you would like to address with Dr. Parker? ___________

____

____

____

____

____

____

____

____

Authorization for Release of Records

Patient Name: ____ Patient DOB: ________________

Parent/Guardian Name: ____

As the parent or legal guardian of the child named above, I authorize Dr. Elizabeth A. Parker and Parker Place to release my child's medical records (to include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers) to, and to receive the same records from, the medical provider(s) named below:

Provider Name: _______________________________________ Phone: ___________________________

Provider Name: _______________________________________ Phone: ___________________________

Provider Name: _______________________________________ Phone: ___________________________

Provider Name: _______________________________________ Phone: ___________________________

Parent/Guardian Signature: ___________________________________ Date: _______________________

PARKER PLACE
49 Old Solomons Island, Suite 303
Annapolis, MD 21403
Phone: 410-844-8998 | Fax: 410-244-6946

Medical Office Policies

Thank you for bringing your child to Parker Place! We strive to make your experience a positive one, and appreciate your cooperation with our office policies:

Medical Practice & Wellness Center Management* Hours of Operation

Monday-Friday, 8:30am-4:00pm

** Note: Wellness center class times vary; please refer to our calendar for specific days/hours.*

Holidays & Observances

Our office and wellness center will be closed on the following days:

New Year's Day	Veterans Day
Martin Luther King, Jr. Day	Wednesday before Thanksgiving
Presidents Day	Thanksgiving Day
Memorial Day	Friday after Thanksgiving
Independence Day	Christmas Eve
Labor Day	Christmas Day
Columbus Day	New Year's Eve

Inclement Weather

Our office and wellness center will abide by Anne Arundel County Public Schools' operating status (closure, delayed opening or early dismissal) for the first day of each separate inclement weather event. For subsequent days, Parker Place will determine its operating status based on weather conditions and staff availability. Please call our office at 410-844-8998 to confirm whether Parker Place is open or closed in the event of inclement weather.

Patient Forms & Documentation

Our patient intake forms can be downloaded from our website, or our office manager can email them to you when you schedule your appointment. Please bring your completed forms with you when you arrive. If you

prefer to complete your forms in our office, please be sure to arrive at least 20-30 minutes prior to your scheduled appointment time.

In addition to your patient intake forms, please be prepared to provide your current insurance card and a valid photo ID. If you or your primary care physician have any of the following documents related to the reason for your appointment, please bring those as well:

- Lab results
- Imaging (e.g. bone age X-rays) on disc or film, and/or reports related to imaging (e.g. bone age report, thyroid ultrasound report, ovarian ultrasound report)
- Growth charts
- Any other documentation pertaining to your endocrine issue

All of these documents may be faxed to our office in advance, either by you or by another provider, at 410-224-6946 or submitted to the office when you arrive.

Lateness, Missed Appointments & Cancellations

Our goal is to see every patient on time, and this requires that we maintain an accurate appointment schedule. Please note that we reserve the right to reschedule any patient who arrives 15 or more minutes late for a scheduled appointment. In addition, if you have chosen not to complete your new patient forms in advance of your arrival, you must arrive at least 20 minutes before your scheduled appointment time in order to complete this paperwork, so that you can be seen by the doctor on time.

Please note that missed appointments (no-shows) will incur a $50 fee that will not be billed to insurance, but directly to the responsible party.

If you need to cancel a scheduled appointment, we ask that you do so no less than 24 hours prior to your appointment time. Cancellations made within 24 hours of the appointment time will be treated as missed appointments (no-shows) and may incur a $50 missed appointment fee.

Questions for the Doctor

In the event of any medical emergency, please call 911. For all other medical questions during business hours, feel free to call the office at 410-844-8998 and leave a message with our staff, so that Dr. Parker can return your call. You can also call this same number after hours and leave a voice mail with your callback number. We make every effort to check voicemail and return calls as quickly as possible on the following business day.

Insurance & Payment

Parker Place accepts most commercial insurances and state-supported plans. To confirm our participation in your plan, please contact our office directly. In addition, please be prepared to provide your current insurance card and photo ID at each visit for verification purposes.

You are responsible for paying any required co-pays at the time of your appointment. Our office will then submit a claim to your insurance company on your behalf, and any remaining balance (whether due to denied claims, non-covered services, or deductibles not met) will be billed to you. Payment for this billed amount must be submitted by the due date stated on the bill itself. Should our office be required to pursue additional collection efforts, you agree to be responsible for any incurred fees.

If you do not have health insurance, full payment for our services is due at the time of your appointment. Please inquire about our self-pay fee schedule.

Please note that, for any other medical services required for your diagnosis or treatment (such as lab work or imaging), you are responsible for paying those service providers directly in accordance with their payment policies and your insurance plan.

For co-pays and additional amounts owed, Parker Place accepts major credit cards (Visa, MasterCard, Discover and American Express), personal checks, and cash.

Updates to Policies

Please note that our policies may be revised periodically as the need arises. We will notify you of any changes by providing you with an updated Medical Office Policies document for signature upon your next visit to our office. If you have any questions regarding our policies, you are encouraged to contact our staff at any time.

I acknowledge that I have received and read Parker Place's office policies.

Parent/Guardian Printed Name: ______________________________

Parent Guardian Signature: ______________________________ Date: ______________

Patient Name: ______________________________

HIPAA Policy & Notice of Privacy Practices

Dear Parent/Guardian or Patient,

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. We ask that you please review it carefully.

The practice has implemented policies and procedures so that the confidentiality of your personal and/or medical information is protected. Your physician, as well as all other employees working in the practice, will keep any information related to you or your child (medical and/or non-medical) in a confidential manner.

So that we may provide you or your child with appropriate medical care, for general practice operations and/or for the purpose of obtaining payment, we will, at our discretion, provide information regarding the treatment you or your child received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health related entities such as:

- Physician/non-physician providers (e.g. physical therapist, nutritional counselor, etc) who work outside of this practice
- Medical facilities (e.g. hospitals and outpatient centers)
- Laboratories for the purposes of running medical tests
- Other health care providers such as pharmacies, durable medical equipment suppliers, and ambulance services
- School health departments
- School nurses
- Insurance companies (or third-party administrators) for the purpose of obtaining payments, reviewing medical necessity and/or general case management
- State or federal agencies that require the submission of specific health related information

This information will be submitted by means of the U.S. Postal Service, fax, Internet, voice mail and/or personal communications.

We may need to contact you, by telephone, to discuss your appointments, test results, treatment, referrals, an account balance and/or return your telephone call. We will call you on the number that you have registered with our practice as your preferred contact number. If you have elected to allow us to send you

secure emails from our practice, we may email you at the address you have provided to our practice. In any messages left via voice mail or email, we may request that you call the office or we may leave information to remind you of an appointment time.

In the event that you do not pay all of your charges at the time of your visit, we will mail a statement to your home. Also, depending upon your situation, we may mail other correspondences to your home noting that we are trying to contact you regarding a scheduled appointment, to schedule an appointment, to mail test result information or other medical and/or non-medical information that you may have requested or information regarding your account in order to collect a debt.

We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your coinsurance and co-pay requirement.

If you would like information sent to another physician or medical facility, you must authorize the release of this information, in writing (we will provide the necessary form to complete) upon registration. Also, you must provide written authorization for the release of information to your life, disability, or future health insurance carrier.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. This may not include psychotherapy notes.

You must submit your request in writing to the Office Manager in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by providing a written request to the practice at any time.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, for example if we think the information is correct, or was not created by our practice, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Office Manager if you have questions about amending your medical record. To file an amendment, your request must be in writing and must be submitted to the Office Manager.

When necessary, these policies will be modified to ensure compliance with the practice operations and with State and Federal privacy regulations.

If you have any questions or concerns with the polies and/or procedures noted above, please contact the Office Manager to discuss them. We trust that you are comfortable with our efforts to maintain confidentiality of the information related to you or your child's medical care.

Sincerely,

Parker Place

This notice was published and becomes effective on July 23, 2018.

Parent/Guardian Signature: ____

Printed Name: ____ Today's Date: ___________________________