

Drs. Hauck, Bianchi, Asher & Driscoll

2415 Musgrove Road, Suite 203

Silver Spring, Maryland 20904

(301) 989-2300

*****PLEASE PRINT*****

MINOR PATIENT'S NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP _____

SEX: M F **DATE OF BIRTH:** ____ / ____ / ____ **SSN:** _____

HOME PHONE: _____

ALLERGIES TO ANY MEDICATIONS? YES NO **NAME OF MEDICATION:** _____

REFERRED BY: _____ **FAMILY DOCTOR:** _____

MOTHER'S NAME : _____

ADDRESS: _____

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____

DATE OF BIRTH: ____ / ____ / ____ **SSN:** _____

DRIVER'S LICENSE # _____ **STATE ISSUED:** _____

FATHER'S NAME : _____

ADDRESS: _____

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____

DATE OF BIRTH: ____ / ____ / ____ **SSN:** _____

DRIVER'S LICENSE # _____ **STATE ISSUED:** _____

*****INSURANCE INFORMATION*****

PRIMARY INSURANCE COMPANY NAME: _____

ID NUMBER: _____ **GROUP NUMBER:** _____

NAME OF INSURED GROUP: _____ **POLICY HOLDER:** _____

SECONDARY INSURANCE COMPANY NAME: _____

ID NUMBER: _____ **GROUP NUMBER:** _____

NAME OF INSURED GROUP: _____ **POLICY HOLDER:** _____

IS ANY OTHER INSURANCE IN EFFECT? YES NO **IS THIS A LEGAL CASE?** YES NO

IS THIS A WORKER'S COMPENSATION CASE? YES NO **DATE OF ACCIDENT/INJURY:** _____

*****AUTHORIZATIONS*****

I, _____, hereby authorize Drs. Hauck, Bianchi & Driscoll, P.A. to apply for benefits on my behalf for services rendered to my minor child and request that payment be made by my insurance company and that payments be sent directly to Drs. Hauck, Bianchi & Driscoll, P.A. I understand that it is the policy of Drs. Hauck, Bianchi & Driscoll, P.A. to only bill my insurance company if they participate in that company, and if they do not, it will be my responsibility to bill my insurance company for reimbursement of my expenses.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to my minor child, and if my account is turned over to an attorney for collection, I agree to pay any collection and reasonable legal fees (25% is deemed reasonable) court costs, and other expenses incurred as a result of said collection, all actions having a venue of Montgomery County, MD, other venues not withstanding. Further, I understand that there is a \$25.00 fee for returned checks.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

SIGNATURE OF RESPONSIBLE PARTY

DATE

FOR OFFICE USE ONLY

UPDATE DATE: _____ INITIALS: _____ CHANGES? YES NO

UPDATE DATE: _____ INITIALS: _____ CHANGES? YES NO

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**NEW/UPDATED MEDICAL HISTORY
PEDIATRIC AND ADOLESCENT**

Please complete all sections

NAME: _____ DATE OF BIRTH: _____ CHILD'S PRIMARY MD: _____

DATE FORM FILLED OUT: _____ DATE OF APPOINTMENT: _____ REFERRING MD: _____

Briefly, what is the child seeing the physician about today? _____

PAST HISTORY

Were there any complications with the pregnancy? YES NO

Were there any complications with the birth? YES NO

Was this child born prematurely? YES NO If yes, how many weeks? _____

Did the child require care in the newborn ICU after birth? YES NO

Did the child fail the newborn hearing screening exam? YES NO

Has the child had any developmental delay? YES NO

Has the child had any problems with growth? YES NO

Has the child ever been hospitalized? YES NO

Has the child ever had surgery? YES NO

Does the child have asthma or any lung disease? YES NO

Does the child have any history of heart disease? YES NO

Does the child have any history of seizures? YES NO

Does the child have any history of allergies? YES NO

Does the child have a history of ADD/ADHD? YES NO

Does the child have any other significant medical problems? YES NO

If you answered **YES** to any of these questions, please give the details below: _____

CURRENT MEDICATIONS (include over the counter medications - and please give dosages): _____

ALLERGIES TO MEDICATION: _____

FAMILY HISTORY - any family history of the following?

Hearing loss? YES NO

Bleeding abnormalities? YES NO

Anesthesia complications? YES NO

Developmental problems? YES NO

If **YES** to any of these, please give details: _____

SOCIAL HISTORY:

- Is the child in daycare? YES NO If yes, how many in group? _____
- Is the child in school? YES NO If yes, what grade? _____
- If in school, is she/he doing well? YES NO
- Is the child living with a smoker? YES NO
- Is the child exposed to tobacco smoke regularly? YES NO
- Are there household pets? YES NO If yes, what kinds? _____

REVIEW OF SYSTEMS:

Any history of the following:

- Ear infections? YES NO
- Hearing problems? YES NO
- Drainage from ears? YES NO
- Speech problems? YES NO
- Nasal congestion? YES NO
- Runny nose? YES NO
- Cough? YES NO
- Snoring? YES NO
- Bedwetting? YES NO
- Mouth breathing? YES NO
- Noisy breathing? YES NO
- Feeding difficulties? YES NO

If **YES** to any of the above, please give details below: _____

Reviewed by: _____ Date: _____