Keun Hee Oh, M.D. **Melissa Levine, M.D.** **Nicholas DeAngelis, M.D.**

Patient Registration Form

Child's Name_____
Full/ Legal Last First MI

Nickname: _____

Date of Birth:_____ Sex M F

Street Address:_____

City, State, Zip_____

Primary Phone Number _____ Home/Cell

*Primary Language:_____

*Ethnicity: Hispanic Non-Hispanic Not Specified

*Race (circle) Asian Black Hawaiian White Unknown

(*Starred information required for federal funding)

PCP (Circle) Dr. Oh Dr. Levine Dr. DeAngelis

Referred by: _____

Parent/Contact #1 (circle) Mother Father Guardian Stepparent Other

Name:_____
Full/Legal Last First MI

Lives with patient (circle) Yes No (if no, complete address)

Street Address _____

City, State, Zip _____

e-mail address _____

print clearly – email address used for patient portal access

Date of Birth_____ SSN _____

Employer: _____

Occupation: _____

Primary Phone _____ Home/Cell

OK to leave voicemail message? Yes No

Other Phone_____ Home/Cell

Work Phone_____

Parent/Contact #2 (circle) Mother Father Guardian Stepparent Other

Name:_____
Full/Legal Last First MI

Lives with patient (circle) Yes No (if no, complete address)

Street Address _____

City, State, Zip _____

e-mail address _____

print clearly – email address used for patient portal access

Date of Birth_____ SSN _____

Employer: _____

Occupation: _____

Primary Phone _____ Home/Cell

OK to leave voicemail message? Yes No

Other Phone_____ Home/Cell

Work Phone_____

SIBLINGS:

Name	Date Birth	Sex

I

CONSENT FOR TREATMENT, RELEASE OF INFORMATION AND RECEIPT OF PRIVACY PRACTICES

I understand that copies of the Notice of Privacy Practices have been presented to me and are posted on our website: www.liebermanpeds.com.

I give my legal permission to Dr. Keun Hee Oh, Dr. Melissa Levine and/or Dr. Nicholas DeAngelis to medically treat my child(ren). I authorize the release of any medical information necessary to process my insurance claims and obtain insurance benefits. I request payment of medical benefits for services provided to be made directly to Laura Lieberman, M.D., P.A. and I understand that I am responsible for any balances not covered under the terms of my medical insurance contract.

I understand that Dr.Oh, Dr. Levine and/or Dr. DeAngelis participate in Immunet, the State of Maryland's immunization registry, and I may opt out of having my child's information sent by notifying the office in writing.

I authorize Dr. Oh, Dr. Levine and/or Dr. DeAngelis, upon my request, to fax immunization records to my child's school.

I understand both biological parents, unless their parental rights have been terminated either through a court order or through adoption process, have access to full disclosure of their child's medical information and can authorize someone else to bring their child to their appointments in their absence.

I understand that a parent or legal guardian must be present for all **WELL CHILD VISITS** and **PRE-OPERATIVE EXAMS**. (We feel it is important to have a parent or legal guardian present for well visits so that we can obtain all of your child's current and relevant personal and family medical history and to provide an opportunity to review your child's growth and development and to answer any questions that you have. (For **SICK VISITS ONLY** you may authorize other individuals to bring your child(ren) to the office).

_____
Signature

_____
Printed Name

_____
Date

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Patient Registration Form

If parents are divorced, separated or do not have custody:
Who has custody?_____

Is there any legal restriction that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical care? **YES** **NO**

IF YES, please explain and provide legal papers supporting this restriction: _____

EMERGENCY CONTACTS

Emergency Contacts (other than parents) who are authorized to bring patients in for **SICK VISITS ONLY**. By authorizing these individuals to participate in your child's health care you are authorizing the office to release Protected Health Information to these individuals in order to care for your child.

Emergency Contact:

1. Name_____

Relationship _____ Phone_____

2. Name_____

Relationship _____ Phone _____

3. Name _____

Relationship_____ Phone _____

NONE – (Please circle)

Signature

INSURANCE INFORMATION***

Insurance Carrier: _____

ID Number: _____

Group Number: _____

Guarantor/Policyholder_____

Secondary Insurance Carrier: _____

ID Number: _____

Group Number _____

Policyholder_____:_____
****Copies of insurance card(s) are required.