



### Pediatric Patient History Update

Name: \_\_\_\_\_

History Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Service: \_\_\_\_\_

**DIRECTIONS:** PLEASE FILL IN THIS FORM AS WELL AS YOU CAN. SKIP OVER ANY QUESTIONS WHICH ARE DIFFICULT FOR YOU. YOUR PHYSICIAN, PRACTITIONER, OR NURSE WILL HELP YOU WITH THEM. (PLEASE PRINT IN BLACK OR BLUE INK)

List current health problems (including behavior & mental health issues):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List current medications and doses (include vitamins & herbal remedies):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES** - Please list any medicines or substances to which the patient is allergic:

\_\_\_\_\_

**HOSPITALIZATIONS / INJURIES:** Please list any operations, hospital admissions, or serious accidents/injuries your child has had. If you've completed this form before, please provide us with an update with any problems in the last three years.

OPERATION, HOSPITALIZATION, or ACCIDENT	DATE (month/year)	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### HOUSEHOLD INFORMATION

Lives With (circle): Both Parents / Mom Primarily / Dad Primarily

Other (please specify): \_\_\_\_\_

Sibling Names/DOB: \_\_\_\_\_

\_\_\_\_\_

Parents' Status (circle): Married / Divorced / Separated / Other

Father's Name: \_\_\_\_\_

Father's Employment: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Employment: \_\_\_\_\_

\_\_\_\_\_

#### SAFETY AND ENVIRONMENTAL EXPOSURES

Exposure to Tobacco Smoke:  Yes  No

Smoke Exposure Location:  Inside  Outside  Both

Pets:  Yes  No

Mold/Mildew:  Yes  No

Lead Paint:  Yes  No

Who Smokes: \_\_\_\_\_

Guns in the House:  Yes  No

Carpets:  Yes  No

Pests/Rodents:  Yes  No

**BIRTH HISTORY:** Please complete for patients currently under one year of age.

Birth Length: \_\_\_\_\_

Birth Weight: \_\_\_\_\_

Birth Head Circ.: \_\_\_\_\_

Discharge Weight: \_\_\_\_\_

Gestational Age: \_\_\_\_\_

Delivery Method: Vaginal / C-Section

Duration of Labor: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

APGAR Score (1 min): \_\_\_\_\_

APGAR Score (5 min): \_\_\_\_\_

Feeding (circle one): Breast / Formula

#### DAY CARE / EDUCATION / EMPLOYMENT

Type of Day Care (check all that apply):

Family Member/Relative/Friend

Child Care Center (commercial)

Home Child Care Provider (day care run from someone's home)

Head Start

Preschool

Prekindergarten





**JOHNS HOPKINS**  
M E D I C I N E

JOHNS HOPKINS  
COMMUNITY PHYSICIANS

**Place Patient Label Here**

**PREVENTIVE MEDICINE SCREENING QUESTIONNAIRE**

**Lead Risk Questionnaire (ages 6 months to 6 years)**

YES

NO

1. Does your child live in or regularly visit a house with peeling, flaking, chipping paint built before 1978? Including but not limited to home, daycare, or relative?

2. Does your child live in or regularly visit a house built before 1978, with recent, ongoing or planned renovations?

3. Does your child have a brother or sister, a housemate, or playmate being followed or treated for lead poisoning?

4. Does your child eat or lick non-edible objects, such as dirt, wood, railings?

5. Does your child live with someone whose job or hobby involves exposure to lead?

6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

**Tuberculosis Risk Assessment (ages 1 month through 21 years)**

1. Was your child born in a high risk country ? (countries other than U.S., Canada, Australia, New Zealand or Western and North European countries) If yes, what country and year.

2. Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?

3. Has your child had a family member or contact with tuberculosis disease?

4. Has your child had a family member with a positive tuberculin skin test result (PPD)?

**Heart Disease/Cholesterol Risk Assessment ( ages 2 through 21 years)**

1. Is there family history of Parent/Grandparent under the age of 55 who underwent a study of the heart blood vessels and were found to have hardening of the arteries? This includes Parent/Grandparent that have undergone balloon heart procedure of bypass surgery.

2. Is there a family history of Parent/Grandparent under the age of 55 who have suffered a heart attack, a stroke, or have angina, or blood vessel disease?

3. Does either Parent have high blood cholesterol (240 mg/dl or higher)?

4. Does the patient (teen/child) have a history of:

Smoking?

Lack of physical activity?

High blood pressure?

High cholesterol?

Obesity/overweight?

Diabetes?

**Mental Health Screening**

1. Have you or your child been the victim of violence or abuse (hit, slapped, hurt)?

2. Is there a recent stress on the family or child such as birth of a child, moving, divorce or separation, death of a close relative?

**STD/HIV Risk Assessment (ages 12 through 20 years)**

1. Has the patient had a blood transfusion or is he/she currently diagnosed with Hemophilia?		
2. Has the patient ever been diagnosed with any sexually transmitted diseases? (gonorrhea, syphilis, venereal warts, chlamydia, herpes)		
3. Has the patient ever been sexually molested or physically attacked?		
4. Any history of IV drug use by patient, patient's sex partner or patient's birth mother during pregnancy?		
5. If sexually active, has the patient had unprotected sex with opposite/same sex partner?		
6. If sexually active, has the patient had more than one sex partner?		
7. Does the patient have any tattoos or body piercings including any performed by friends?		



OUTPATIENT AGREEMENT FORM

## OUTPATIENT AGREEMENT FORM

Patient Identification Information

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This form applies to the following Johns Hopkins Medicine ("Johns Hopkins") entities: Johns Hopkins Bayview Medical Center, Clinical Practices of the Johns Hopkins University School of Medicine, Howard County General Hospital, Johns Hopkins Community Physicians, Johns Hopkins Home Care Group, Suburban Hospital, Sibley Memorial Hospital, Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. and The Johns Hopkins Hospital, Johns Hopkins Imaging, and Ambulatory Surgery Centers.

**General Policy:** All patients shall be treated without discrimination related to age, race, ethnicity, religion, culture, language, physical or mental disability, social or economic status, gender, sexual orientation, or gender identity or expression.

**Consent for Treatment:** I, or my representative, agree to have Johns Hopkins providers evaluate and treat my condition. Absent an emergency, if the proposed treatment has significant risks, then an additional informed consent will be obtained. I understand that the practice of medicine is not an exact science, and that no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.

**Disclosure & Authorization to Release Information:** I hereby authorize Johns Hopkins to release my final diagnosis and other medical information to third parties to determine benefits payable and process claims. I authorize Johns Hopkins to release medical information to my insurance carrier for payment purposes. I authorize Johns Hopkins and/or any physicians who render services to me to release all or part of my medical and billing records for treatment, payment, and operations and for those purposes outlined in the Johns Hopkins Notice of Privacy Practices.

**Consent to be Contacted:** I agree that by providing my landline, cell phone number(s) or email address, I am giving express consent for Johns Hopkins, its staff, employees, independent contractors, assignees, successors, and agents, to contact me through email or at these numbers, or any number or email address that is later acquired for me and to leave live or pre-recorded messages, text messages or emails regarding my healthcare-related matters, my account, or my bill related to any services I receive. I confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Additionally, for my convenience, emails and text messages may be sent unencrypted, which may present certain risks, including the risk of being intercepted during transmission or viewed by someone other than me. I agree to accept these risks. If I do not wish to receive text messages, I can call 1-800-318-4246 to opt-out. Providing an email address or telephone or cell phone number is not a condition of receiving services.

**Physicians Not Employees of the Hospital:** I understand that physicians may not be employees of the health system. I understand that my physician may ask other physicians to participate in my care including but not limited to attending physicians, radiologists, surgeons, obstetricians/gynecologists, pathologists, anesthesiologists, neonatologists, physicians interpreting diagnostic studies, consultants and physician assistants. I also agree that physicians in training, students or other qualified health care personnel, under supervision of my physician, may participate in and/or observe my care unless I specifically state otherwise, either verbally or in writing.

**Electronic Prescribing:** I authorize Surescripts, an electronic prescribing network, to release my medication refill history to my providers for the purpose of continued treatment.

**Payment for Services:** I understand that Johns Hopkins may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Johns Hopkins. If I should receive the payments, I understand that I will be responsible for paying Johns Hopkins. I assign the benefits payable for health care services to the physicians and/or organizations furnishing the services. I authorize direct payment to Johns Hopkins and all other providers of service to me, of any insurance, personal injury or other benefits otherwise payable to me or the patient. I acknowledge the financial responsibility for any coinsurance, deductible or other sum not received by the hospital from any third party source for the care and services rendered to me or the patient. I assign my right to appeal a denial of payment to Johns Hopkins for services rendered to me.

I understand that Johns Hopkins may be treated as an out of network provider by my health plan for services rendered at Johns Hopkins. In such case, my copay or deductible may be greater than if services were rendered at an in network facility or lab. This means that your insurance may cover less than expected depending upon your health plan. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay including a higher deductible or copay as a result of out of network benefits. I know that I may need to pay this before I am treated.

Patients seen in a clinic or outpatient setting may receive multiple bills. The hospital is permitted to bill a fee for outpatient visits, commonly referred to as a "facility fee", for the use of hospital facilities or space, clinics, supplies, tests, procedures, equipment, and non-physician services, including but not limited to the services of non-physician clinicians. I understand that all professional services of physicians are billed separately from the hospital bill. I understand that I am responsible for the charges of all physicians and ancillary services involved in my treatment.

I understand that hospital rates for hospitals located in the State of Maryland are subject to change without notice during the course of my outpatient treatment. This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia. This does not apply to Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. located in Florida.

I understand that at Maryland hospitals I am entitled to a Prompt Payment hospital discount as follows: 2% if payment is made on or before the date of service, or 1% if payment is made within 30 days of the date of the first bill or date of discharge, whichever is earlier. This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia, or Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. located in Florida.

I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. If my account is sent to a collection agency, I agree to pay all reasonable fees that are required to collect what is due. These fees may include court costs, attorney's fees of 15% of the billed charges and interest at the judicial rate if judgment is entered.

**ERISA:** If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have Johns Hopkins act on my behalf to obtain my benefits when Johns Hopkins asks to do so. I also agree that Johns Hopkins can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

**Private Contract:** I understand that Johns Hopkins will hold me responsible in any one of the following situations. I may be asked to review and sign the Private Contract form in addition to this form:

- (1) When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.

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- (2) When I choose not to use my health plan and agree to pay for services myself.
- (3) When my health plan does not participate with Johns Hopkins for the services I want or need and I agree to pay for my care myself.
- (4) When I receive services that are not covered under my health plan.

**Assignment of Benefits:** I assign to Johns Hopkins the right to submit a pre-service appeal to my health plan on my behalf.

**Mediation Agreement (applicable to Maryland only):** I understand that any claim that may arise out of the care provided from the doctors, nurses and other health care providers at any Johns Hopkins entity located in the state of Maryland are governed by the laws of the State of Maryland. I agree that before I file any lawsuit, I will try to resolve my claim through mediation. Mediation is a process through which a neutral third person assists the parties to help settle the claim. I do not give up my right to file a lawsuit if the mediation process fails to resolve my claim. I agree that any mediation or action in court must take place in Maryland. This agreement is binding on me and anyone who makes a claim for me.

**The Johns Hopkins Notice of Privacy Practices:** I received a copy of the Johns Hopkins Notice of Privacy Practices.

**Consent for the Creation and Use of Photographs, Audio and Video Recordings (PAVR):** I acknowledge that I have received the Johns Hopkins Photographs, Audio and Video Recording Patient Information Guide. I agree to allow for the creation and use of photographs, audio and video, recordings (PAVR), and other images and recordings of me, or the patient I represent, for the purposes of internal education and quality improvement.

Initial one: \_\_\_\_\_ I authorize \_\_\_\_\_ I do not authorize

**Other Tests:** In the event that a member of the hospital's work force sustains a bodily fluid exposure during the course of my treatment, I consent to HIV testing and authorize the hospital to release the result of this said test to me, the exposed healthcare employee, and my physician. I understand that I have the right to refuse testing without penalty. \_\_\_\_\_ I authorize \_\_\_\_\_ I do not authorize

**Interpreter:** If interpreter used, please complete the following:  Remote  In-person

Interpreter ID Number (if phone/video interpreter used): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Printed Name of Interpreter: \_\_\_\_\_

**I AGREE TO THE ITEMS STATED ABOVE AND CERTIFY THAT ALL INFORMATION PROVIDED INCLUDING INSURANCE IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. NO CHANGES TO THIS FORM WILL BE ACCEPTED.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

For health care agent / guardian / surrogate / parent / spouse (circle one), I, \_\_\_\_\_ (print name), am the representative for the patient.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Representative's signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

### JOHNS HOPKINS NOTICES

**Pathology:** Johns Hopkins may dispose of any tissue or parts that are removed during a procedure; may retain, preserve, use, and share these tissues, parts or related information for internal educational and quality improvement purposes without my permission (even when these tissues, parts or related information identify me); and may use or share tissues, parts or related information that identifies me for research with my permission or with the approval of a review board governed by federal laws protecting these activities. If tissues, parts or related information do not identify me, Johns Hopkins may use them for scientific (research) purposes without my permission or action by a review board.

**Pathology (Florida):** I authorize Johns Hopkins to dispose of any tissue or parts that are removed during a procedure; to retain, preserve, use, and share these tissues, parts or related information, including any related DNA analysis, for internal education, research, quality improvement and other healthcare operations purposes, and as otherwise permitted by federal and state privacy laws, even when these tissues, parts or related information identify me.

**Personal Belongings:** Patients are responsible for their personal belongings and are encouraged to leave all money and valuables at home. Johns Hopkins shall not be responsible or liable for the loss of or damage to any personal property the patient brought into the facility including but not limited to money, dentures, glasses, hearing aids, personal electronic devices and documents.

**Financial Assistance:** I understand that Johns Hopkins has Financial Assistance Policies which provide financial assistance and payment plans to patients under certain circumstances. I understand that I can request information concerning Johns Hopkins Financial Assistance by contacting the Customer Service Department for Johns Hopkins at 443-997-3370 or 1-855-662-3017. I hereby authorize Johns Hopkins to run a credit report on me for use in determining whether I qualify for financial assistance or a payment plan. I also understand that I can obtain information by going online at: [www.hopkinsmedicine.org/patient\\_care/pay\\_bill/payment\\_assistance.html](http://www.hopkinsmedicine.org/patient_care/pay_bill/payment_assistance.html)

Physicians have their own financial assistance policies and the patient should contact the physician's office to inquire.

**Advance Directives:** An Advance Directive can mean any written or spoken statement of wishes regarding healthcare that is listed in the medical record. Advance Directives tell your health care providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself. Examples include an appointment of a healthcare agent, healthcare instructions/treatment preferences (e.g., "Living will"), oral Advance Directive, and/or Advance Directive for Mental Health Services. If you have a written Advance Directive, please give a copy to the Registrar, your Nurse or Physician. If you would like to complete an Oral Advance Directive or revoke or revise an existing Advance Directive, please inform the Registrar, your Nurse or Physician.

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### The Johns Hopkins Photographs, Audio and Video Recordings (PAVR) Patient Information Guide:

#### Internal Education and Quality Improvement

Please review this Information Guide before signing the Photographs, Audio and Video Recordings (PAVR) consent portion of The Johns Hopkins Inpatient or Outpatient Agreement form. Photographs, video, and audio recordings (PAVR) created and used at Johns Hopkins for the purposes of internal quality improvement and education are designed to improve patient care. Examples of how PAVR may be used include:

- **Quality Improvement Use- Video monitoring preparation the patient for surgery to prevent infection and ensure compliance with standards of care.**
- **Internal Education- The proper way to treat a wound, insert an IV or perform a procedure.**

**Protecting your privacy:** Johns Hopkins is grateful to patients who are willing to allow us to create and use PAVR so that we can improve the care we provide. At the same time, the privacy of patients, as well as the confidentiality of medical and related information, are among our highest priorities

- During the creation of PAVR, your privacy is protected as much as possible, and whenever possible the PAVR will be modified so that you are not recognizable.
- The Johns Hopkins staff will explain any intended use of the PAVR and answer any questions you may have.
- Use of your PAVR for purposes other than internal education and quality improvement shall require your additional consent and/or authorization.
- PAVR may include, but is not limited to photographs, drawings, video or audio recordings, digital or electronic images, motion pictures or other images

It is important that you **understand your rights** when PAVR is created or used. Your rights include:

- Consent for the creation and use of PAVR is voluntary. Your treatment will not be impacted, based on whether you sign the consent or not.
- Your consent will end only when the use of your information is no longer needed for the purposes of internal education and/or quality improvement.
- You may verbally request cessation of the creation of PAVR at any time while it is being made.
- You hereby release and waive all claims for compensation and rights to the images and recordings for which you consent.
- Following the creation of images and recordings you may revoke or withdraw your consent by mailing or faxing your written request to the care provider, clinic or department where your consent was made or given or to the Health Information Department. This withdrawal would affect only any new use of your PAVR by Johns Hopkins. If all identifiers have been removed from the PAVR this may not be feasible.

Please be sure to ask a Johns Hopkins staff member to clarify any questions you may have. We appreciate your assistance, and value your participation.



EP-00008

**JOHNS HOPKINS INSTITUTIONS**

**STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS**

. Complete all sections of this Authorization as appropriate to your request.

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
(first) (m. initial) (last)

**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
(street address)

\_\_\_\_\_ **Medical Record #:** \_\_\_\_\_  
(city) (state) (zip code) (if known)

For this Authorization, "**My Health Care Provider**" means \_\_\_\_\_  
(name of health care provider)

For this Authorization, "**My Health Information**" means any and all information relating to my course of examination and treatment.

**If I have initialed here (\_\_\_\_\_), "My Health Information" includes Substance Abuse Records/Information.**

**If I have initialed here (\_\_\_\_\_), "My Health Information" includes Mental Health Records/Information.**

I authorize My Health Care Provider to discuss My Health Information with the person(s) or entity identified below for general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- If I do not sign this Authorization, My Health Care Provider will not disclose My Health Information as requested.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: \_\_\_\_\_. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

**Signature of Patient Only:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required)



If you are NOT the patient but are signing on behalf of the patient, complete the following:

I, \_\_\_\_\_, am the (check which applies)  
(print your name)

- Parent with Parental Rights** *(not sufficient for substance abuse records)*
- Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
- Court Appointed Guardian**
- Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
- Medical Power of Attorney** *(not sufficient for substance abuse records)*
- Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
- Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
- Court Appointed Personal Representative of Deceased**

Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).



**FORMAT:** I request that the copy be provided (where possible/available):

- on paper                                       electronically on CD                                       electronically on flash drive
- through a web portal, with notice provided to my email account at: \_\_\_\_\_
- by unencrypted e-mail to this email address: \_\_\_\_\_
- by other electronic means (if agreed upon by JH records department): \_\_\_\_\_

**Important:** I understand that the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive **My Health Information** on a CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of My Health Information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: \_\_\_\_\_. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
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(Required)

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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## Day of Appointment Checklist

Insurance Card and Co-pay



Name & Number of your emergency contacts



### **Bring the following medications in the Original Bottle or Packaging:**

- Prescription Medications
- Over the Counter Medications
- All Vitamins and Minerals
- All Herbal Supplement



### **Discharge Papers from:**

- Emergency Room Visit
- Hospital Admission



### **List of Specialist Seen**

- X-Ray
- Orthopedics
- Cardiology



Immunization Record

