Laura Lieberman, M.D. **Melissa Levine, M.D.** **Keun Hee Oh, M.D.**

	First Child	Second Child	Third Child	Fourth Child
First Name, Middle Initial				
Last Name				
Name that child likes to be called				
Sex	_____Male _____ Female	_____Male _____ Female	_____Male _____ Female	_____Male _____ Female
Date of Birth				
Primary Language Spoken				
Ethnicity	____ Hispanic ____Not Hispanic ____ Unknown ___ Not specified	____ Hispanic ____Not Hispanic ____ Unknown ___ Not specified	____ Hispanic ____Not Hispanic ____ Unknown ___ Not specified	____ Hispanic ____Not Hispanic ____ Unknown ____ Not specified
Race	____ Native American ____ Black ____Pacific Islander ____ Asian ____ Unknown ____ White ____Decline to specify	____ Native American ____ Black ____Pacific Islander ____ Asian ____ Unknown ____ White ____Decline to specify	____ Native American ____ Black ____Pacific Islander ____ Asian ____ Unknown ____ White ____ Decline to specify	____ Native American ____ Black ____Pacific Islander ____ Asian ____ Unknown _____ White _____ Decline to specify
Primary Care Provider	_____ Dr. Lieberman _____ Dr. Levine _____ Dr. Oh	_____ Dr. Lieberman _____ Dr. Levine _____ Dr. Oh	_____ Dr. Lieberman _____ Dr. Levine _____ Dr. Oh	_____ Dr. Lieberman _____ Dr. Levine _____ Dr. Oh

Please request additional form if Primary and Secondary Contact information is not the same for all children listed.

PRIMARY CONTACT PERSON FOR THE FAMILY

Check One: ____ Biological Mother _____ Stepmother _____ Adoptive Mother _____ Foster Mother _____ Legal Guardian Other: _____
_____ Biological Father _____ Stepfather _____ Adoptive Father _____ Foster Father _____ Legal Guardian Other:_____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Work Phone: _____ Email*_____

City:_____ State:_____ Zip:_____ Birth Date:_____

Do you live with the patient? _____Yes _____ No Referred by: _____ Name of Employer: _____

Preferred method of contact (Please circle) Home Phone Cell Phone Work Phone Text Email Mail None

**Your email address will be used for access to our patient portal. We recommend using a personal, rather than business, email address. You can change and update your information and preferred method(s) of contact in the patient portal.*

SECONDARY CONTACT PERSON FOR THE FAMILY

Check One: ____ Biological Mother _____ Stepmother _____ Adoptive Mother _____ Foster Mother _____ Legal Guardian Other: _____
_____ Biological Father _____ Stepfather _____ Adoptive Father _____ Foster Father _____Legal Guardian Other:_____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Work Phone: _____ Email*_____

City:_____ State:_____ Zip:_____ Birth Date:_____

Do you live with the patient? _____Yes _____ No Name of Employer: _____

Preferred method of contact (Please circle) Home Phone Cell Phone Work Phone Text Email Mail None

If parents are divorced, separated or do not have custody: Who has custody?_____ Is there any legal restriction that would restrict 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: _____

In order to obtain more accurate Family MEDICAL History requirements, if contacts listed above are NOT the biological parents, please list BOTH BIOLOGICAL parents (if known).

Biological Mother:_____ Date of Birth:_____

Biological Father:_____ Date of Birth:_____

If either biological parent has NO parental rights per SIGNED COURT ORDER, a copy of that COURT ORDER is required to be on file.

EMERGENCY CONTACT PERSON (other than either the parent(s) or contact(s) listed above

Name: _____ Relationship to patient: _____ Phone: _____

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Copayments and balances are due at the time of service.

If insurance cards are not presented and/or insurance cannot be verified, you may be considered self pay.

	First Child	Second Child	Third Child	Fourth Child
First Name, Middle Initial				
Last Name				
Primary Insurance Company Name				
Policyholder/Guarantor				
Insurance ID Number				
Group Number				
Copay, Coinsurance and/or Deductible				
State Medical Assistance ID number (if Applicable)				
Secondary Insurance Company Name				
Secondary Insurance ID Number				
Secondary Group Number				
Secondary -Copay, Coinsurance and/or Deductible				
State Medical Assistance ID number (if Applicable)				

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. Laura Lieberman, Dr. Melissa Levine and/or Dr. Keun Hee Oh 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. Lieberman, Dr. Levine and/or Dr. Oh 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. Lieberman, Dr. Levine and/or Dr. Oh, 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).

I authorize the following individuals to bring my child(ren) in for sick visits and are authorizing these individuals to participate in my child's health care. I authorize the release of Protective Health Information to these individuals in order to care for my child(ren).

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Signature _____ Printed Name: _____

Relationship to Patient(s) _____ Date _____