Mohsin Ansari M.D., FAAP, PC

Faryal Durrani, M.D. & Heesung Sean Kim, P.A.

OFFICE #1- 106 Pine Bluff Rd Suite 11 | Salisbury, MD 21801 | Phone: (410) 742–2255 Fax: (410)742-2589

OFFICE #2- 7001 Johnnycake Rd Suite 102| Windsor Mill, MD 21244| Phone: (410) 744 KIDS (5437)

Fax: (410) 744-5436

Patient's Name: ____ Date of Birth: ____ / ____ / ____

Address: _________________________________ City/State: __________________ Zip: ___________

Social Security #: ____________________ Phone (Home): ________________ (Cell): ______________

Race: ________________ Ethnicity: ___________________ Preferred Language: __________________

Primary Care Physician: ___________________________

Name of Emergency Contact(s): _________________________________

Relationship to you: __________________ Emergency Contact Number(s): ________________________

Work Phone:______________

Reason for Visit:____

Parent (Mother) / Guardian Information:

Full Name:______________________________________ Maiden Name:_______________________

Date of Birth: ____ / ____ / ____ Social Security: ____________________

Marital Status: _________________ Employer: _____________________________________

Home Address: __________________________ City: ________________ State: _______ Zip:_______

Home #:(____) ____________ Cell: _________ Work: _____________ ext: _____

Parent (Father) / Guardian Information:

Full Name:______________________________________ Maiden Name:_______________________

Date of Birth: ____ / ____ / ____ Social Security: ____________________

Marital Status: _________________ Employer: _____________________________________

Home Address: __________________________ City: ________________ State: _______ Zip:_______

Home #:(____) ____________ Cell: _________ Work: _____________ ext: _____

Allergies

☐ No Known Allergies

☐ Yes. If so, please list all Drug, Food, Environmental Allergies and state reaction.

____

Medications

☐ No Current Medications

Please list all current medications that you are taking and their corresponding dosages (if known):

Preferred Pharmacy

Name: _________________________________ Location/Street: ______________________________

Phone Number: __________________________

UNITED MEDICAL

Please check if specify if anyone in your family (Mother, Father, Sister, Brother, Maternal Grandmother, Paternal Grandmother, Maternal Grandfather, and Paternal Grandfather) had the following:

Family History	YES	NO	WHO
Alcohol Drug Disease	☐	☐	___________
Allergies	☐	☐	___________
Birth Defects	☐	☐	___________
Blood Disorders	☐	☐	
Cancer	☐	☐	
Deficit Disorder	☐	☐	
Diabetes	☐	☐	
Family Violence	☐	☐	
Hearing Loss	☐	☐	
Heart Disease	☐	☐	
Hepatitis Liver Disease	☐	☐	
High Blood Pressure	☐	☐	
HIV / AIDS	☐	☐	
Kidney Disease	☐	☐	
Learning Problems	☐	☐	
Seizures	☐	☐	___________
Speech Problems	☐	☐	___________
Suicides Attempts	☐	☐	___________
TB Lung Disease	☐	☐	___________
Thyroid Disease	☐	☐	___________
West Nile Disease	☐	☐	___________
Other:	_________________		

Personal Medical History

Has your child ever have: (Please check)

Allergies:___
Blood Disorders:___
Bone / Joint Disorder:___
Chicken Pox:___
Depression / Suicides Attempts:___
Diabetes:___
Ear Infections:___
Emotional Behavior:___
Heart Disease:___
High Blood Pressure:___
Hospitalization / Surgeries:___
If yes, please describe: _______________
____
Kidney Disease:___
Learning Problems:___
Liver Disease:___
Obesity / Eating Disorders:___
Physical/Emotional/Sexual Abuse:___
Seizures: ___
Skin Problems: ___
STD's:____
TB Lung Disease:___
Vision / Hearing Problems:___
Other: ___________________________

Pregnancy and Birth History

Hospital: ________________________
Illness during Pregnancy: Y / N Type of delivery:
Vaginal / C- section Patient's Birth weight: _____
Problems at Birth: Y / N Describe: ___________________
Medications during Pregnancy: Y / N
Did baby receive hepatitis B Vaccination: Y / N Not sure Date of Vaccination: ___ ___ / ____

Psychosocial History

Who lives in the House hold: _______ How Many: _____ Rent: ___Own: __ Shelter: _____
Who cares for your child: __________ Foster Care: _____ Dates: ________________________
Other Languages: ___________ Tobacco Use: ____Current: ___ Past: ___ Never: ________

Guarantor Responsibility

As a patient you have certain responsibilities for your care. Those responsibilities include:

1. Providing current, accurate billing info at each visit
2. Provide physician with complete medical history
3. Being aware of your insurance coverage, including covered and non-covered benefits
4. Providing secondary insurances: for example (court ordered absent parents) It is the parents responsibility to know this information

Please pay co-pay/ deductible/ balance at each visit. Failure to do so will result in additional fees. I hereby, authorize treatment by Dr. Ansari & his associates & agree to pay all fees & charges for such treatment. I authorize the release of any pertinent information to my insurance company & other doctors involved in my care. I hereby, authorize my insurance benefits to be paid directly to Dr. Ansari. I agree to be financially responsible for due balances. If my account becomes assigned to a collection agency, I agree to pay 25% collection agency fees, court costs & attorney fees. I understand that all accounts with a balance over 30 days will be passed a 1.5% late charge per month on the unpaid monthly balance.

Acknowledgement for Secondary Insurance

I acknowledge that the Insurance information provided by me today is accurate and complete. I also acknowledge that I will be responsible for any payments for this visit and all future visits, if insurance carrier retracts or denies fee for service because of inaccurate / lack of information provided by me on today's visit.

Notice of Privacy Policies

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as the quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

My signature acknowledges understanding and consent to all of the above information.

Patient's Printed Name: ____ **Date:** __________________

Parent/Lawfully Authorized Personnel Signature: ____

UNITED
MEDICAL