THE GREATER BALTIMORE CLEFT LIP AND PALATE TEAM
GBMC HEALTHCARE
6535 North Charles Street, Suite 250
BALTIMORE, MARYLAND 21204
TELEPHONE: 443-849-6050 FAX: 443-849-3010

Patient Registration

Patient Name _____Sex_____ Date of Birth ___/____/___

Social Security # _____

Primary Care Provider's (doctor) Name: _____Phone _____

Address: _____
Street City State Zip Code

Patient's Parent Information:

MOTHER: _____
Last First (Maiden)
Date of Birth ___/____/_____ SSN _____

Street Address _____

City, State, Zip _____

Home Phone (_____)_____

e-mail address: _____

Employer _____

Occupation _____

Business Phone _(_____)_____

Business E-mail _____

Business Address _____

City, State, Zip _____

FATHER: _____
Last First
Date of Birth ___/____/_____ SSN _____

Street Address _____

City, State, Zip _____

Home Phone _(_____)_____

e-mail address: _____

Employer _____

Occupation _____

Business Phone __(_____)_____

Business E-mail _____

Business Address_____

City, State, Zip _____

Emergency Contact: Name _____ Phone _____

Primary Insurance Company Name _____

Policy Number _____ Group Number _____

Effective Date _____ Expiration Date _____

Insurance company Address _____

Insurance Company Phone: _____

Subscriber Name _____ Birth date _____ SS# _____

Relationship to Patient _____ Phone _____

I certify that the demographic and insurance information provided above is current and accurate to the best of my knowledge. I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to Greater Baltimore Medical Association for services rendered to me.

_____ _____
Signature of Patient's Parent or Financially Responsible Party Date

Patient Allergy

Any known patient allergies: Yes No Unknown

If any allergies, please list allergen and patient's reactions: _____

_____

Secondary Insurance Coverage

Secondary Insurance Company Name: _____

Insurance Claims Address: _____
Street City State Zip Code

Insurance Phone: _____

Subscriber Name: _____

Patient's Relationship to Subscriber: (Circle One) Parent Spouse Self Dependent Other

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Birth date: _____ Social Security Number: _____

Subscriber's Phone: _____ Subscriber's e-mail: _____

Subscriber's Employer's Name: _____

Employer's Phone: _____

Employer's Address: _____
Street City State Zip Code

Effective Date of Insurance: _____ Co-Payment: _____

Policy #: _____ Group #_____

Guarantor

Name: _____

Address:_____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Guarantor's relationship to patient (circle one): Parent Spouse Self Child Dependent Other: _____

Guarantor's Employer

Name: _____

Address: _____
Street City State Zip Code

Phone: _____ e-mail address: _____

Greater Baltimore Cleft Lip and Palate Team
Greater Baltimore Medical Center
6535 North Charles Street, Suite 250
Baltimore MD 21204

AUTHORIZATION FOR RELEASE OF YOUR DOCTORS

Patient Information:		
Patient Name	Birth Date	Social Security Number
Address		Telephone Number

Release Of Information:
I hereby authorize the following physician(s) to release health information from the medical records of the above named patient to the Greater Baltimore Cleft Lip and Palate Team (Please use an extra sheet if more space is required.)

1. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

2. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

3. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

4. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

5. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

Type of Access Authorized	
o Copies of the record o Inspection of the record	o Continuing care information (discharge summary, history and physical, consultation, operative report, diagnostic and medical tests, pathology report, growth chart, development reports) o Other _____

THIS IS A TWO-SIDED FORM. THE PATIENT OR REPRESENTATIVE MUST SIGN ON THE BACK.

Greater Baltimore Cleft Lip and Palate Team
Greater Baltimore Medical Center
6535 North Charles Street, Suite 250
Baltimore MD 21204

Name: _____

Birth Date:

AUTHORIZATION FOR RELEASE OF YOUR DOCTORS

This authorization will expire one year from the date signed below unless specific expiration event or condition is named here:

_____.

The authorization covers only the treatment for the dates specified above. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.

I , the undersigned have read the above and authorize the staff of the disclosing facility to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that disclosure of health information to a party other than the one(s) designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Confidential Information".

_____ _____

Date Signature of Patient

_____ _____

Date Signature of Parent, Guardian/Authorized Representative

_____

Relationship to Patient

Fees/charges will comply with all laws and regulations applicable to release of information.

Prohibition on Redisclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Greater Baltimore Cleft Lip and Palate Team
Greater Baltimore Medical Center
6535 North Charles Street, Suite 250
Baltimore, MD 21204

Name:

Birth Date: _____

AUTHORIZATION FOR RELEASE OF CLEFT TEAM

(Side 1 of 2-Please Complete Both Sides)

Patient Information:		
Patient Name	Birth Date	Social Security Number
Address		Telephone Number

Release Of Information:

I hereby authorize the Greater Baltimore Cleft Lip and Palate Team to release health information from the medical records of the above named patient to the following physician(s). (Please use an extra sheet if more space is required.)

1. Name: _____
   Address: _____
   _____
   Phone :_____ Fax: _____

2. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

3. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

4. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

5. Name:_____
   Address:_____
   _____
   Phone :_____ Fax: _____

Type of Access Authorized	
o Copies of the record o Inspection of the record	o Continuing care information (discharge summary, history and physical, consultation, operative report, diagnostic and medical tests, pathology report) o Other _____

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Greater Baltimore Cleft Lip and Palate Team
Greater Baltimore Medical Center
6535 North Charles Street, Suite 250
Baltimore MD 21204

Name:

Birth Date: _____

AUTHORIZATION FOR RELEASE OF CLEFT TEAM

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_____.

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I the undersigned, have read the above and authorize the staff of the disclosing facility to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that disclosure of health information to a party other than the one(s) designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Confidential Information".

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Parent, Guardian/Authorized Representative

_____
Relationship to Patient

Fees/charges will comply with all laws and regulations applicable to release of information.

Prohibition on Redisclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Greater Baltimore Cleft Lip and Palate Team
Greater Baltimore Medical Center
6535 North Charles Street, Suite 250
Baltimore, MD 21204

Name:

DOB:

CONSENT FOR TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of

_____

give my consent and authorize the administration and performance of all treatment and diagnostic procedures, including taking of laboratory tests, which, in the judgement of the Team's licensed physicians and other health care providers, are considered necessary, I am aware that the practice of medicine is not an exact science and that no guarantee can be made concerning the results of treatment. The minor(s) named on this consent form may receive all medical care provided according to generally and currently accepted standards of pediatric medical care.

My consent is effective for the following time period:

From_____ to _____ (if to present, write present.)

Parent/Legal guardian

Name:_____ Relationship to minor:_____
Name:_____ Relationship to minor:_____

In the absence of the legal guardian, the following people are authorized to bring the minor(s) named above for medical treatment and have access to his/her medical information. (You may name relatives, friends, grandparents, stepparent, non-custodial parent, day care provider, foster parent, or others.)

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

If no other person is authorized, please write 'NONE' _____

(Over, Please)

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Name:

DOB:

CONSENT TO TREATMENT OF A MINOR

Please read and initial the following as acknowledgement of your consent:

_____If the minor is brought by any person not recorded above, the Cleft Lip and Palate Team will make reasonable attempts to contact me for verbal consent to treat.

_____I understand that consent from parents, legal guardian or, in the absence of parents or legal guardians, the authorized person(s) named above is required for all non-emergency situations.

_____I have the right to revoke or change this consent to treat in writing.

_____If the custody or guardianship of this minor has changed, I will furnish the Cleft Lip and Palate Team with the legal forms that are required to be included in the minor's medical record to explain the change in guardianship.

Parent/legal guardian signature:

Signature:_____ Date:_____

Relationship:_____ Witness:_____

GREATER BALTIMORE CLEFT LIP & PALATE TEAM
MEDICAL PHOTOGRAPHY AUTHORIZATION

I consent to photography of my child's face in connection with his/her physical examination and/or surgical procedure.

I understand that such photographs or imaging records may be used for the purposes of primary care physician communication, medical education, patient counseling, and/or electronic media.

My child will never be identified by name in any publication or electronic media presentation; although I understand that the photographs may portray features that could make my child's identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation. I also understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment my child receives from the Greater Baltimore Cleft Lip & Palate Team.

I release and discharge the Greater Baltimore Cleft Lip & Palate Team physicians and all parties acting under their licenses and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use, including any claim for payment in connection with the distribution or publication of the photographs.

I grant this consent as a voluntary contribution and certify that I have read the above Authorization and Release and fully understand its terms.

Parent or Legal Guardian (signature) (printed name) Date

Witness (signature) (printed name) Date

Child's Name Date of Birth