

**THE MARYLAND PEDIATRIC GROUP, L.L.C.**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

MPG primary provider: \_\_\_\_\_

Best telephone number to reach you regarding this form: \_\_\_\_\_

1. a. List current or active medical problems:

1. b. List significant past medical problems:

2. List past surgeries with month/year of procedure:

3. List any specialists your child has seen in the past year, and reason for visit:

4. List all medication your child takes on a daily basis (unless otherwise noted, these medications will be included as medications your child will be taking at camp/school). Please include dosage and time of day your child takes medication. Please include OTC medications taken daily:

5. List any allergies (foods, medications, latex, seasonal, etc.)—if none, please write NONE:

6. Does your child wear glasses or contact lenses?

7. Is there any other significant information we need to be aware of? If yes check here \_\_\_\_\_ (explain details on reverse side)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FOR OFFICE USE ONLY:**

Patient's Name: \_\_\_\_\_

Date Received: \_\_\_\_\_

Mail to: \_\_\_\_\_

Call for Pick Up: \_\_\_\_\_

Fax To: \_\_\_\_\_

Fee Paid: \_\_\_\_\_

Standard form \$20 \_\_\_\_\_

Family Patient Balance: \_\_\_\_\_

Initials (Staff Intake): \_\_\_\_\_

Initials (Staff Completing Form): \_\_\_\_\_