**Pre-Appointment Forms**
Dr. Antonie Kline
Harvey Institute for Human Genetics
Greater Baltimore Medical Center

***Dear Family,***

Thank you for your interest in an appointment with Dr. Antonie Kline. We look forward to meeting you and your child. In the meantime, we ask that you complete the following forms so that we can be prepared for your child's appointment. Please complete as much information as possible. If you have any questions or concerns, please feel free to contact us at 443-849-3131, opt 4 then opt 1.

**INSTRUCTIONS:**

1) If you type directly into this form, you need to use Adobe software. If you have an Apple computer, DO NOT use the default Apple PDF reader software. You need to use Adobe reader to open and complete this form, otherwise the form comes back blank to us.

2) Please complete these forms to the best of your ability. Once you have completed the forms, please send them back for review.

**Completed questionnaires can be returned by:**

1. **Mail to:** Dr. Antonie Kline; 6701 N. Charles St, Ste 2326, Baltimore, MD 21204
2. **Fax to:** 443-849-2919 (Attention: Dr. Antonie Kline).
3. **E-mail:** Please e-mail to dberry@gbmc.org

3) Once we receive your completed forms, we will contact you to schedule an appointment and we will request your child's medical records. If an emergent appointment is needed, we can schedule the appointment before receiving these completed forms.

**FREQUENTLY ASKED QUESTIONS:**

*1) What happens during the appointment?*
The initial visit usually lasts about 90 minutes. You will meet with Dr. Kline and one of the genetic counselors. We will review your child's medical and family history and examine your child. With your permission, photographs may be taken. At the end of the visit, all findings are reviewed with you and recommendations are made. The referring physician is contacted immediately by fax or telephone if urgent, and subsequently receives a written summary of the visit, a copy of which is also sent to you.

*2) Why should we come for a genetics evaluation?*
Your doctor has identified a medical, physical, developmental, and/or behavior difference in your child compared to his/her peers. The genetic evaluation will help identify if this could be genetic in your child or inherited from the family. This would be useful to know from the diagnosis and management point of view.

*3) Will there be genetic testing?*
Genetic testing may be recommended to diagnosis or rule out a genetic condition. Other testing may also be recommended. Most testing is done by obtaining a blood or urine sample. This will be reviewed at the visit.

*4) Could any of this affect our future children or our other children?*
If we can diagnose a genetic condition in your child, then we will be able to give you very specific information about the chance of recurrence for your future children and/or other family members. If not, we can often offer empirical risks, or an educated guess about the chances of recurrence in the family.

**For more information, visit our web site at: www.gbmc.org/genetics**

## Harvey Institute for Human Genetics/GBMC Healthcare

# PEDIATRIC PATIENT REGISTRATION

Patient's First Name: _____ Patient's Middle Initial: _____

Patient's Last Name: _____ Patient's Gender: _____

Patient's Date of Birth (mm/dd/yyyy): _____ Patient's SSN: _____

Patient's Race: _____ Patient's Religion: _____

Pediatrician/PCP's Name & Phone #: _____

Pediatrician/PCP's Address: _____

Emergency Contact Name & Phone #: _____

**Parent/Legal Guardian #1's Name:** _____ Date of Birth: _____

Relationship to Patient: _____

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

E-mail: _____

Home Address: _____

City _____ State _____ Zip Code _____

**Parent/Legal Guardian #2's Name:** _____ Date of Birth: _____

Relationship to Patient: _____

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

E-mail: _____

Same address as parent/legal guardian #1? ☐ Yes ☐ No: please provide below

Home Address: _____

City _____ State _____ Zip Code _____

## How May We Contact You?

☐ Home phone ☐ Cell phone ☐ Work phone ☐ E-Mail ☐ Letter

☐ Other: _____

May we leave a detailed voice-mail message? ☐ Yes ☐ No

May we leave a detailed message with anyone listed on the "Consent to Treatment of a Minor" form? ☐ Yes ☐ No

Patient's Name: _____ Patient's Date of Birth: _____

## PATIENT'S INSURANCE

**Primary Insurance:**

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

**Secondary Insurance:**

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

Patient's Name: _____ Patient's Date of Birth: _____

## I. CLINICAL STATISTICAL INFORMATION

The following information will be used to help maintain quality care and assure we are meeting our patient's needs

**Mother/Parent/Guardian #1**

Educational level: (check one please) ☐ 8th grade or less ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Some college
☐ College degree ☐ Advanced degree ☐ Other: _____

Race: _____ Marital status: _____

Occupation: _____

**Father/Parent/Guardian #2**

Educational level: (check one please) ☐ 8th grade or less ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Some college
☐ College degree ☐ Advanced degree ☐ Other: _____

Race: _____ Marital status: _____

Occupation: _____

**Child usually lives with (check one please):**

☐ Mother/Guardian #1 ☐ Father/Guardian #2 ☐ Both ☐ Other: _____

## II. REASON FOR APPOINTMENT

What Is the reason for this appointment or why does your child's doctor want you to see us?

What questions do you want us to answer?

Patient's Name: _____ Patient's Date of Birth: _____

## III. PATIENT'S MEDICAL HISTORY

Mother's age at birth? _____ Father's age at birth? _____

Hospital of birth? _____

Birth Weight: _____ Birth Length: _____ Head circumference: _____

Length of stay in hospital after delivery for **baby** (in days): _____

Did your baby have any unusual physical features at birth? ☐ Yes, please explainbelow ☐ No

Was the pregnancy conceived naturally? ☐ Yes ☐ No, please explain below

Were there problems or complications at delivery? ☐ Yes, please explain below ☐ No

Were there any feeding problems? ☐ Yes, please explain below ☐ No

Immunizations are: ☐ Up to date ☐ Incomplete

Allergies (include medication and non-medication allergies):

Patient's Name: _____ Patient's Date of Birth: _____

## Hospitalizations & Surgeries:

| Date/Year | Name of Hospital | Reason for Admission or Surgery |
|---|---|---|
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| | | |
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## Development:

At what age (in months or years) did your child:

Roll over: _____

Sit up without support: _____

Stand while holding on: _____

Pull to stand _____

Walk well: _____

Gaze at parent's face: _____

Reach for toys: _____

Transfer objects between hands: _____

Finger feed: _____

Drink from a cup: _____

Use a spoon: _____

Scribble: _____

Draw pictures: _____

Wave goodbye: _____

Toilet train: _____

Undress him/herself: _____

Dress self: _____

Tie shoes: _____

Coo, babble: _____

Point to body parts: _____

Speak single words: _____

Say dada and/or mama: _____

Speak two words together: _____

Knows his/her colors: _____

Please report your child's IQ (if known): _____

Date & location of developmental assessment: _____

Patient's Name: _____ Patient's Date of Birth: _____

# CURRENT MEDICATIONS

Date Completed: _____

Please list all prescription and non-prescription medications and supplements. Please provide dosage and frequency of use (for example: 10mg once a day OR 10mg three times a day)

| MEDICATION | DOSE | FREQUENCY | REASON FOR MEDICATION | ROUTE (mouth, injections, eye drops, etc) |
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Reviewed by Physician. Physician's Signature: _____

Patient's Name: _____ Patient's Date of Birth: _____

## IV. FAMILY HEALTH HISTORY

**Does anyone in the mother or father's families have the following conditions? If yes, please report relationship.**

Cancer: _____

Cystic fibrosis: _____

Cleft lip or palate: _____

Spina bifida: _____

Bone problems: _____

Bleeding problems (like hemophilia): _____

Muscular dystrophy or muscle weakness: _____

Neurofibromatosis: _____

Mental retardation or learning disability: _____

Hearing loss or deafness: _____

Vision loss or blindness: _____

Seizures: _____

Heart problems from birth: _____

Diabetes: _____

Anemia ("low blood"): _____

Lung problems: _____

Other birth defects (explain): _____

Other inherited/genetic problem (explain): _____

Harvey Institute for Human Genetics
Greater Baltimore Medical Center
6701 N. Charles Street, Suite 2326
Baltimore MD 21204
Phone: 443-849-3192; Fax: 443-849-2919

# Authorization for Release of Protected Health Information

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Patient's Telephone #: _____

**I hereby authorize exchange of protected health information (including: history and physical information, consultation notes, discharge summary, operative reports, pathology reports, and diagnostic, medical, and genetic test results) between the following individuals and Dr. Antonie Kline.**

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

Name: _____ If a Physician, Speciality? _____

Address: _____

Phone: _____ Fax: _____

☐ You may request records from this source ☐ You may send my Genetics records to this source

Name: _____ If a Physician, Speciality? _____

Address: _____

Phone: _____ Fax: _____

☐ You may request records from this source ☐ You may send my Genetics records to this source

Name: _____ If a Physician, Speciality? _____

Address: _____

Phone: _____ Fax: _____

☐ You may request records from this source ☐ You may send my Genetics records to this source

Name: _____ If a Physician, Speciality? _____

Address: _____

Phone: _____ Fax: _____

☐ You may request records from this source ☐ You may send my Genetics records to this source

Patient's Name: _____

Date of Birth: _____

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## Authorization for Release of Protected Health Information (Continued)

Authorization for release of Genetics records 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".

Prohibition on Redisclosure: This information has been disclosed to the listed individuals from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit the listed individuals 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.

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

Signature of Patient: _____ Date: _____

Signature of Parent, Guardian, or Authorized Representative: _____

Printed Name of Parent, Guardian, or Authorized Representative: _____

Date: _____