CalvertHealth™
Medical Group

Primary Care
Pediatric Health Questionnaire

Today's Date: _____

Thank you for taking the time to complete this form, which is necessary to provide the 'complete picture' of your child's health. It includes information about the home and school/daycare environments as well information regarding all healthcare received outside of our office. By gathering this information, we will be better able to offer your child the best care possible. **Please bring a copy of your child's immunization record with you to your first appointment.**

Patient Name: _____ DOB: _____ Age: _____ Sex: ☐M ☐F

Address: _____

Name of parent or legal guardian: _____ ☐ Parent ☐ Guardian

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

Best to contact: (circle one)
Home Work Cell

Reason for today's visit: _____

Names of parents and siblings. Please also list any others living with the child (extended family, step-family, grandparents, etc.)	DOB	Relationship to Child

1. **Patents marital status:** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Never Married** ☐ **Other** _____
2. If parents are not living together or if the child does not live with parents what is the child/s custody status?
   _____
3. Parent's Occupation: Parent 1_____ Parent 2_____
4. Child's daytime status: ☐Home ☐Daycare ☐School
5. Does anyone in the household smoke? ☐No ☐Yes
6. Does anyone at daycare smoke? ☐No ☐Yes ☐Not applicable
7. Are there pets in the home? ☐No ☐Yes If yes, type and quantity:
8. Are there pets in daycare? ☐No ☐Yes ☐Not applicable
9. Are there firearms in the home? ☐No ☐Yes
   a. ☐They are hidden away without gun locks.
   b. ☐They are hidden away but have gun locks on them.
   c. ☐They are locked up in a gun safe or cabinet.
   d. ☐Other: _____

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Primary Care
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Patient Name: _____ DOB: _____

FAMILY HISTORY – (check all that apply) – please circle P for paternal or M for maternal when choosing a grandparent.

☐ Cancer	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Asthma	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Nasal Allergies	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Diabetes (before age 50)	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ High Blood Pressure	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ High Cholesterol	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Heart Disease (before age 50)	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease)	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Kidney Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Liver Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Bleeding Disorder	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Mental Illness	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Epilepsy or Seizures	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Alcohol Abuse	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Drug Abuse	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Deafness	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Tuberculosis	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Bet-wetting (after age 10)	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Immune Problems	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ HIV or AIDS	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M
☐ Unexplained Sudden Death (before age 50)	☐ Mom	☐ Dad	☐ Brother	☐ Sister	☐ Grandmother P / M	☐ Grandfather P / M

CalvertHealth™
Medical Group

Primary Care
Pediatric Health Questionnaire

Patient Name: _____ DOB: _____

BIRTH HISTORY (please print)

1. Was the child adopted? ☐ No ☐ Yes (if yes, please answer the questions below):
   At what age? _____
   From what country? _____
   Were the birth parents known to you? ☐ No ☐ Yes
2. Birth weight? _____ ☐ Unknown
3. How many weeks gestation? _____ ☐ Premature ☐ Full Term ☐ Unknown
4. Delivery: ☐ Vaginal ☐ Cesarean (Why? _____)
5. Did your baby have any problems right after birth? ☐ No ☐ Yes (If yes, please explain below)

   _____
6. Initial feeding: ☐ Breast ☐ Bottle ☐ Unknown
7. Did mother have any illnesses or problems with pregnancy ☐ No ☐ Yes (if yes, please explain below)

   _____
8. During pregnancy, did the mother:
   a. Smoke? ☐ No ☐ Yes
   b. Drink alcohol? ☐ No ☐ Yes
   c. Use drugs or medications? ☐ No ☐ Yes (if yes, please explain below)

   _____
9. Did your baby go home with the mother from the hospital? ☐ No ☐ Yes (If NO, please explain below)

   _____

DEVELOPMENTAL HISTORY (please print)

10. When did child:
    a. Sit up? ☐ Normal ☐ Delayed ☐ Unknown
    b. Walk? ☐ Normal ☐ Delayed ☐ Unknown
    c. Speech development? ☐ Normal ☐ Delayed ☐ Unknown
11. Has your child ever been evaluated or diagnosed with a developmental delay? ☐ No ☐ Yes (if yes, please explain below)

    _____
12. How is your child in school?
    a. How is he/she doing in academic subjects? _____
    b. Is he/she in a special resource class? ☐ No ☐ Yes
    c. Has he/she failed or repeated a grade? ☐ No ☐ Yes
    d. Has he/she been diagnosed with a learning disorder? ☐ No ☐ Yes (if yes, please explain below)

    _____

CalvertHealth™
Medical Group

Primary Care
Pediatric Health Questionnaire

Patient Name: _____ DOB: _____

Preferred Pharmacy: _____

CURRENT MEDICATIONS (You may bring your own list to your appointment if you prefer.)

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	Example: 500Mg	Example: 1 pill three times a day

* Note: this information may be taken directly from the pharmacy label on prescription products.

ALLERGIES

☐ No known allergies	☐ Medication Allergies	☐ Environmental/Seasonal Allergies	☐ Latex Allergy
List Allergies		Reaction	

PAST SURGICAL HISTORY (please list any previous surgeries or hospitalizations)

Type of Surgery (operation) or hospitalization	Date

PAST INJURIES OR ACCIDENTS (please list any serious injuries or accidents)

Type of injury or accident	Date

CalvertHealth™
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Primary Care
Pediatric Health Questionnaire

Patient Name: _____ DOB: _____

MEDICAL HISTORY: Does your child have, or has he/she ever had the following: (Please indicate date and any explanation)

Condition			**Date and explanation if any**
Chicken Pox	☐ No	☐ Yes	_____
Frequent ear infections	☐ No	☐ Yes	_____
Problems with hearing or ears	☐ No	☐ Yes	_____
Food or environmental, allergies	☐ No	☐ Yes	_____
Problems with vision or eyes	☐ No	☐ Yes	_____
Asthma	☐ No	☐ Yes	_____
Frequent bronchitis or pneumonia	☐ No	☐ Yes	_____
Recurrent croup	☐ No	☐ Yes	_____
Other chronic/serious lung disease	☐ No	☐ Yes	_____
Tuberculosis or positive TB Skin Test	☐ No	☐ Yes	_____
High blood pressure	☐ No	☐ Yes	_____
High cholesterol	☐ No	☐ Yes	_____
Heart murmur	☐ No	☐ Yes	_____
Congenital or acquired heart defect	☐ No	☐ Yes	_____
Anemia or bleeding problem	☐ No	☐ Yes	_____
Blood transfusion	☐ No	☐ Yes	_____
Frequent abdominal pain	☐ No	☐ Yes	_____
Constipation requiring doctor visits	☐ No	☐ Yes	_____
Bladder or kidney infections	☐ No	☐ Yes	_____
Bed-wetting (after ager 5)	☐ No	☐ Yes	_____
Thyroid or endocrine problem	☐ No	☐ Yes	_____
Any chronic or recurrent skin problem (acne, eczema, etc.)	☐ No	☐ Yes	_____
Frequent headaches	☐ No	☐ Yes	_____
Convulsions/neurological problems	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Cancer	☐ No	☐ Yes	_____
HIV/AIDS	☐ No	☐ Yes	_____
Sexually transmitted infections	☐ No	☐ Yes	_____
Emotional disorder or suicide attempts	☐ No	☐ Yes	_____
Behavior disorder (ADHD, ODD, etc.)	☐ No	☐ Yes	_____
Psychiatric disorder	☐ No	☐ Yes	_____
Use of alcohol	☐ No	☐ Yes	_____
Other	☐ No	☐ Yes	_____

For Girls:

Has she started her menstrual periods? ☐ No ☐ Yes When?_____

Are there problems with her periods? ☐ No ☐ Yes _____

CalvertHealth™
Medical Group

CalvertHealth Medical Group
PO Box 11759
Newark, NJ 07101-4759
USA
(410) 414-4555

PATIENT INFORMATION

NAME (Last, First/Preferred Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	CURRENT GENDER	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#

NAME OF INSURED	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$

CITY, STATE ZIP	PHONE	DEDUCTIBLE
		$

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#

NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$

CITY, STATE ZIP	PHONE	DEDUCTIBLE
		$

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I certify all of the above information is accurate to the best of my knowledge.

SIGNATURE OF PATIENT/GUARDIAN

DATE

CalvertHealth™
Medical Group

Consent to Care and Treatment

Patient Name: _____ DOB: _____

As a patient, you have the right to be informed about the state of your health and any recommended medical, diagnostic or surgical procedure that will be used in the course of your care at this practice so that you may make informed decisions as to whether or not to undergo any recommended treatment.

If you have been a patient of this practice prior to signing this consent, any medical conditions and/or treatment plans have already been discussed with you and you consent to the ongoing care and treatment that has been defined.

If you are a new patient with this practice, no specific treatment plan has yet been recommended.

This consent form gives us your permission to examine you and perform the evaluations necessary to evaluate your health and identify any conditions that may be affecting it. It also gives us your consent to recommend appropriate treatment for any conditions identified during the course of your care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing in order to assess your health and recommend treatment. You authorize this practice, your assigned physician and/or advanced practice clinician (Nurse Practitioner or Physician Assistant), and any employee working under the direction of the physician or other advanced practice clinician, to provide medical care to you. This medical care may include services and supplies related to your health and may include but not limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the prescribing of drugs, devices, equipment or other items required to diagnose and treat a medical condition. This consent includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment.

You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the purpose, potential risks and benefits of any test ordered for you in the course of your treatment plan with your physician or health care provider. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms specific to the test(s) or procedure(s) to be performed.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Patient Signature (or Guardian if signing for another person)	Date
_____	_____
Name of Guardian	Relationship to Patient
_____	_____
Witness	Witness Name (please print)

CalvertHealth™
Medical Group

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing CalvertHealth Medical Group (CMHG) as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment of your bill is part of your care. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

Insurance: Please confirm your provider is enrolled with your insurance carrier prior to scheduling your visit.
We participate in most insurance plans, including Medicare. If you are not insured by a plan we accept, or if you choose to submit your claim yourself, payment in full is expected at each visit. We will provide you with appropriate documentation so that you can submit a claim to your insurance company.

If we do participate in your plan, but you do not have a **current insurance card** or the **designated primary care provider** is not a CHMG provider, payment is required in full for each visit until we verify coverage. Alternatively, if we do not participate in your insurance plan and you choose to see our providers, or if you do not have insurance and choose to see our providers, you will be considered 'self-pay' subject to the terms defined later in this document.

Proof of Insurance: If you have insurance and we submit claims on your behalf, we require a copy of your driver's license or other government issued photo ID and your current insurance card at each visit. This information must be provided prior to seeing a provider (physician, nurse practitioner or physician assistant).

Claims Submission: Your insurance benefit is a contract between you and your insurance company, and the charges for any services provided are your responsibility. We will submit claims to your insurance (primary and secondary or supplemental) company on your behalf. In order to submit claims, we require the patient's name, address, and date of birth, as well as the policyholder's name, address, and date of birth. This information must match exactly what your insurance company has on file for you, including exact name, address, and policy number. Any missing or incorrect information provided may result in claims being denied or reimbursement being delayed, in which case you may become responsible for the full amount of the services provided.

Coverage Changes: Please notify us before your scheduled appointment if any of your insurance information has changed. This includes changes of employer, insurance provider, address, policy number, covered dependents, etc. Not having up-to-date information may result in claims being denied or delays in reimbursement in which case you will become responsible for the full amount of the services provided.

Co-Payments: If your insurance company requires co-payments, those co-payments must be paid at the time of service. We collect co-pays during appointment check in.

Deductibles and Out-Of-Pocket Expenses: We will bill you for any outstanding balance once your insurance company has processed your claim and made payment to us. This balance may include your contracted deductible or other out-of-pocket expense as determined by your insurance policy. Payment for outstanding balances is expected within 30 days of the statement date and/or at your next appointment.

Referrals: It is your responsibility to obtain any necessary referrals from your primary care provider prior to receiving treatment. Patients who elect to receive service without a proper referral will be required to sign a waiver and will be expected to pay for the service prior to treatment.

Payment: We accept payment by cash, debit card, check, VISA, MasterCard, Discover, and American Express. All outstanding balances must be paid at time of service unless prior arrangements/payment plans have been set up. As a convenience to our patients, all CHMG practices are able to collect payments for all other CHMG practices.

Returned Check Fee: We charge a $25.00 fee for returned checks. In the event a check has been returned the patient must pay by credit card or cash. If a second check is returned, in addition to the returned check fee, you will be asked to pay by cash, money order, cashiers' check, or credit card for all future visits.

CalvertHealth™
Medical Group

Patient Financial Policy

Self-Pay: A Self-Pay patient is any patient who does not have health insurance; chooses to submit their own claims, see a CHMG provider who does not participate in their health insurance plan, receive a service that requires a referral from their insurance company or primary care provider when they do not have the referral with them or receives a treatment they know is not covered by their insurance company.

Financial Assistance: The Practice has payment plans, financial assistance, and sliding fee scale, to uninsured and others with self-pay balances. Please ask the office assistant for further information.

Non-Payment: If a balance remains unpaid past 90 days your account will be transferred to a collection agency or collection attorney. In the event your accounts remain in delinquent standing with the collection agency, you may be terminated from the medical group.

Minor Patients: Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for payment for all services rendered to the minor child at the time of the appointment.

Physicals: Department of Transportation (DOT), 500, sports, camp and work physicals are not usually covered by any insurance companies. Payment for these services are expected at the time of service.

Personal Injury Claims: CHMG will bill the current health insurance for treatment covered by the insurance company. All applicable co-pays will be collected at time of service.

Account Consultation: Providers (physicians, nurse practitioners, physician assistants) are not trained to discuss financial issues with patients. Only CHMGs billing staff is trained to discuss your account, including charges, fees, payments, and payment arrangements. If you have questions about any of the financial issues related to your account, please contact the **billing office at 410-414-4555.**

Worker's Compensation: Prior authorization is required from your employer before service can be provided. We require the following information for each claim submitted on each date of service: state where injury occurred (i.e. Maryland); date of injury; exact location on the body where the injury occurred and that is covered by the claim. If the claim is denied and you do not have health insurance, the charges will become your responsibility.

CHMG Billing Contact Information:

Physical Address
CHMG Billing Office
Prince Frederick, MD 20678
Billing Phone Number: 410-414-4555

Mailing Address
CHMG Billing Department
PO Box 11759
Newark, NJ 07101-4759

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial and payment policy.

My signature below certifies that I have read, understand, and agree to the terms of this Patient Financial Policy.

Patient Signature: _____ Today's Date: _____

Patient Name: _____ DOB: _____

CalvertHealth™
Medical Group

Patient Privacy Policy

The Right to Obtain a Copy of this Notice. You have the right to a paper copy of this notice at any time. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask at registration or contact our Privacy Officer at the address or phone number located at the end of this document. You may obtain a copy of this notice at our website, www.CalvertHealthMedicalGroup.org.

Your Rights Regarding Your Protected Health Information. We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for your PHI we already have as well as any information we receive in the future. We will post a copy of the current notice. The notice will always contain on the first page, the effective date of the Privacy Notice.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us and the Secretary of the Department of Health and Human Services. All complaints must be in writing and sent to the address provided at the end of this notice. You will not be penalized for filing a complaint.

Contact Information
If you require further information about this Notice, have privacy issues or believe that your privacy rights have been violated, please contact:

CalvertHealth Medical Group
Attn: Privacy Officer
100 Hospital Road
Prince Frederick, MD 20678
410.535.4000

Effective Date
This Notice is effective January 1, 2021.

By signing this document, I acknowledge that I have read and understood this Privacy Notice and that a copy of CalvertHealth Medical Groups Privacy Notice was offered to me.

Patient Signature	Date
Print Name	DOB

CalvertHealth™
Medical Group

No Show/ Late Policy

Patient Name: _____ DOB: _____

Thank you for choosing CHMG as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. We understand there are times when you must miss a scheduled appointment or cannot cancel or reschedule in a timely manner; however, when you do not call to cancel a scheduled appointment at least 24 hours prior to the appointment or miss a scheduled appointment without notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

To help avoid misunderstandings, we are providing you with our No Show and Late Cancellation/Reschedule Policy. For purposes of this policy, a late cancellation is when a patient cancels or reschedules a scheduled appointment but provides less than 24 hours' notice. Late cancellations will be treated as a 'no-show' per CHMG policy.

The following policies will apply to 'no-shows' and late cancellations/reschedules, combined, on a rolling 12 month period.

'No-Shows' and late cancellations/reschedules for Office Visits:

- First offense will prompt a warning letter to the patient regarding their no-show or late cancellation/ reschedule occurrence and a notation will be made in the patient's chart.
- Second offense will prompt a phone call from the practice to the patient and 2nd warning letter will be sent to the patient.
- Third offense will prompt the patient to be discharged from the practice. The patient will receive a letter of discharge by certified mail and the patient portal.

'No-Shows' or late cancellations/reschedules for Procedure:

- Patient will automatically be charged a $100 'no-show' or late cancellation/reschedule fee. The practice staff will print a copy of the signed No-Show and Late Cancellation/Reschedule Policy along with the fee ticket, and mail to the patient.

Additional Information:

The No-Show and Late Cancellation/Reschedule Policy is not provider specific but applies across all CHMG practices, such that a no-show or late cancellation/reschedule for one provider could impact the patient's ability to schedule appointments with another CHMG provider. **For a listing of all CalvertHealth Medical Group providers and practices, please go to CalvertHealthMedicalGroup.org.**

All applicable no-show and late cancellation/reschedule fees must be paid prior to scheduling future appointments with any CHMG provider.

My signature below certifies that I have read, understand and agree to the terms of the No Show and Late Cancellation/Reschedule Policy.

Patient Signature: _____ Today's Date: _____

CalvertHealth™
Medical Group

Patient Ethnicity and Race Form

Today's Date: _____

Patients Name: _____ Date of Birth: _____ MRN: _____

The State of Maryland is requesting CalvertHealth Medical Group inquire about the ethnicity and race for each patient in order to be in compliance with the Patient Centered Medical Home. **Patient is not required to complete this form. If this form is not complete, the staff will input "Not Specified".**

Question 1. Ethnicity
Are you Hispanic or Latino?
(A patient of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture of origin, regardless of race.)

☐ Yes ☐ No ☐ Unknown/Not Specifying

Question 2. Please select the racial category with which you most closely identify by placing an 'X' in the appropriate box.

RACIAL CATEGORY	DEFINITION OF CATEGORY
☐ American Indian or Alaska Native	A patient having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
☐ Asian	A patient having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
☐ Black or African American	A patient having origins in any of the black racial groups of Africa.
☐ Native Hawaiian or Other Pacific Islander	A patient having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ White	A patient having origins in any of the original peoples of Europe, the Middle East or North Africa.
☐ Multi-Racial	A patient having origins of more than one Racial Category identified above.
☐ Unknown/Not Specifying	A patient whose race is unknown OR a patient who does not wish to supply race information.

Information obtained from the Office of Management and Budget.