



Patient Name _____

Birthdate _____

Review of Systems (Please check all that apply)

Constitutional

- Fever/chills
- Excess weight loss/gain
- Loss of appetite

Respiratory

- Cough
- Wheezing
- Chest tightness

Skin

- Rash
- Diaper rash
- Skin lesions

Eyes

- Blurry vision
- Eye redness
- Eye discharge

Gastrointestinal

- Nausea/Vomiting
- Diarrhea
- Constipation
- Blood in Stools

Neurological

- Headache
- Numbness
- Weakness

Ears/Nose/Throat

- Ear pain
- Ear discharge
- Hearing Loss
- Congestion
- Sore Throat

Genitourinary

- Discharge – penis or vagina
- Pain with urination
- Abnormal periods
- Bedwetting

Psychiatric/Emotional

- Depression
- Anxiety
- Insomnia
- Stress

Cardiovascular

- Chest pain
- Fainting (syncope)
- Tiring easily with exertion

Musculoskeletal

- Joint pain
- Joint swelling
- Muscle pain

Endocrine

- Increased thirst
- Increased drinking
- Temperature intolerance

Allergy

- Sneezing
- Itching eyes
- Hives



NEW PATIENT INFORMATION

Patient Last Name:	Name of Guarantor (Responsible Party):
Patient First Name:	Address:
Patient Middle Name:	City: State:
Address:	Relationship to patient:
City: State:	Date of Birth:
Zip:	Social Security No.:
Mom Cell:	Phone: () _____ - _____
Dad Cell:	Emergency Contact Information
Home Phone:	Name:
Sex: M F	Relationship:
Date of Birth:	Phone:
Primary contact <input type="checkbox"/> MOM <input type="checkbox"/> DAD	Mobile Phone : () _____ _____
Parent email:	
Required by government mandate [although you may refuse]:	Employer information
Language:	Employer:
Race:	Address:
Ethnicity:	Phone:
Marital Status:	
Other	Pharmacy Information:
Patient Referred by:	Name:
	Crossroads:
Insurance Information	
Insurance Plan Name:	Address:
Last Name (Of the policy holder):	City:

First Name (Of the policy holder):	State:
Middle Name:	Zip
Date of Birth (Of the policy holder):	Sex (please circle): M or F
Employer Name:	Employer Address:

To the best of my knowledge, the above information is complete and accurate.

Signed _____ Date: _____

ACKNOWLEDGEMENT AND AUTHORIZATION: PLEASE READ ALL STATEMETNS BELOW AND SIGN

- I have been given the opportunity to read the HIPAA/Privacy Policy for Gwinnett Pediatrics and Adolescent Medicine.

Signed _____ Date: _____

- I hereby assign my insurance benefits to be paid directly to Gwinnett Pediatrics and Adolescent Medicine. I authorize Gwinnett Pediatrics and Adolescent Medicine to release medical information required to process my claims for services received. I authorize Gwinnett Pediatrics and Adolescent Medicine to pursue any unpaid or incorrectly adjudicated claims.

Signed _____ Date: _____

- I have read and understand the Financial Policy for Gwinnett Pediatrics and Adolescent Medicine. I understand that I am responsible for all amounts not covered by my health insurance.

Signed _____ Date: _____

- I authorize Gwinnett Pediatrics and Adolescent Medicine to obtain/have access to my medication and vaccine history.

Signed _____ Date: _____

- I authorize Gwinnett Pediatrics and Adolescent Medicine to contact me with automated text alerts. (text alerts will notify you if lab results are available, provide appointment reminders, and other important office messages.)

Signed _____ Date: _____

- I authorize Gwinnett Pediatrics and Adolescent Medicine to leave messages regarding my child's health on my voicemail.

Signed _____ Date: _____