Patient Name_____

Birthdate _____

Review of Systems (Please check all that apply)

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

Eyes
- ☐ Blurry vision
- ☐ Eye redness
- ☐ Eye discharge

Ears/Nose/Throat
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Hearing Loss
- ☐ Congestion
- ☐ Sore Throat

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

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Chest tightness

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

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

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain

Skin
- ☐ Rash
- ☐ Diaper rash
- ☐ Skin lesions

Neurological
- ☐ Headache
- ☐ Numbness
- ☐Weakness

Psychiatric/Emotional
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Stress

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 ☐ MOM ☐ 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:** _____