GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

PATIENT REGISTRATION INFORMATION

Date_____ **Patient Acct #**_____

PATIENT INFORMATION

Name:_____
First **Middle Initial** **Last**

Date of Birth:_____ **Sex:** □ Male □ Female

Address:_____ **City, State, Zip:**_____

Home Phone:_____ **Mom Work Phone:**_____ **Mom's Cell:**_____

Dad's Work Phone:_____ **Dad's Cell:**_____

Email Address:_____
(We send out appointment notices via email) ***We can text appointment reminders.***

GUARANTOR INFORMATION *(Responsible Party / Will be SELF if patient is 18 yrs or older)*

Name:_____
First **Middle Initial** **Last**

Date of Birth:_____ **Sex:** □ Male □ Female **Social Security#:**_____

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Other** **Relation:**_____

Address:_____ **City, State, Zip:**_____

EMERGENCY CONTACTS

Emergency Contact Name:_____ **Relation:**_____

Phone #1:_____ **Phone #2:**_____

Nearest Relative (not living with you):_____ **Relation:**_____

Phone #1:_____ **Phone #2:**_____

INSURANCE INFORMATION *(copy of insurance card required to file insurance)*

Primary Insurance Carrier Name:_____

Address:_____ **City, State, Zip:**_____

Insurance Phone #:_____ **Effective Date:**_____

Policy Holder Name:_____ **Group #**:_____**Patient ID#:**_____

Relationship to Patient:_____ **Birthdate**:_____**Social Security #:**_____

Name & Address of Employer_____

Your signature below indicates your consent for treatment of /as patient and responsibility for the payment of the bill. Thank you.

_____ **Date:**_____
Guardian or Patient Signature

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

FINANCIAL POLICY

Gwinnett Pediatrics is committed to providing you with the best possible medical care for your child. We believe that an informed consumer is a more satisfied consumer. Therefore, in our effort to communicate, we offer you our Financial Policy in writing to keep with your family's medical receipts.

The following information is provided to avoid any misunderstandings or disagreement concerning payment for professional services.

I understand that whoever brings my child in for visits is authorized to receive financial and medical information.

FINANCIAL INFORMATION: Payment is required at the time services are rendered. If you are unable to pay your bill today, please ask to speak with a Financial Advocate. He/She will assist you with arranging a payment plan, discussing financial assistance, or rescheduling an appointment for a time when you are prepared to pay.

Regardless of your insurance coverage, you are ultimately responsible for full and timely payment of all charges incurred at Gwinnett Pediatrics. If you fail to make payment in full or arrange for a payment plan with our financial department for the services that are rendered to you, your outstanding balance may be sent to a collection agency and you may be terminated from our Practice. You may be responsible for the fees assessed by the collection agency.

Because our practice is charged per call for after-hour calls to the CHOA advice line, we request that you contact your insurance advice line first. You may be charged $15.00 for calls that are routed to the CHOA line or the physician on call.

INSURANCE INFORMATION: Our practice participates with a variety of insurance plans and it is your responsibility to:

- Be familiar with the requirements of your specific plan. We handle families covered by more than 1,000 health plans and cannot be responsible for understanding the current details of every plan.
- You are **required** to present your current insurance card at every visit.
- Your co-payment, coinsurance and/or deductible are **required** at each visit. Payment can be made by cash, check, or credit card. If you do not bring payment to your visit and we have to bill you, your visit may be rescheduled or you may be assessed a $5 processing fee.
- For medical care **not covered** under your insurance, payment in full is due at the time of the visit.
- Secondary medical insurance will be filed upon your request only and we will be happy to provide you with a claim form in case that you want to submit to your secondary carrier yourself. Please ask the financial advocate for assistance. If you have insurance that we do not participate in, we will file the claim upon request; however, payment in full is expected at the time of service.
- If you change insurance, please be sure to notify our billing office with this information as soon as possible otherwise you may be responsible for the entire bill.
- If you have questions regarding your insurance, we will be happy to help you; however, specific coverage issues should be directed to your insurance company member services department.

CANCELLATIONS AND MISSED APPOINTMENTS: If it is necessary to cancel your check up appointment, please do so 24 hours prior to your appointment or your account may be assessed a $50 late cancellation/missed appointment fee. If you miss your sick child appointment your account may be assessed a $25 fee.

If you are divorced, please note that the party that brings the child to the office will be the responsible party on record. We will not be involved in parental court cases.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication.

How should we contact you: home _____ cell _____ text _____

Please sign below to acknowledge that you have read and agree to this financial policy.

_____

Signature of Patient or Responsible Party Date

Patient Name: _____ Date of birth: _____

GWINNETT PEDIATRICS AND ADOLESCENT MEDICINE

Release of Medical Information

Main Office

3540 Duluth Park Lane
Suite 150
Duluth, GA 30096
Fax #: 770-476-0947

601-A Professional Drive
Suite 370
Lawrenceville, GA 30046
Fax #: 770-995-7018

2089 Teron Trace.
Suite 100
Dacula, GA 30019
Fax #: 770-831-7285

Telephone: 770-995-0823

I hereby request and authorize Gwinnett Pediatrics to use and disclose protected health information ("(PHI)") for the following child(ren) listed below:

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

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

Home Phone #_____ Cell or Other Phone _____

Current Address _____ City/State/Zip_____

This Authorization applies to the following date(s) of service:_____

Complete Medical Records ($10.00 per Child)
Patient Summary of all visits
Immunizations Only
Radiology/ EKG/ Lab Reports

Chart Notes
Consultation Notes
Other:_____

**Medical Records Fee must be paid before the records are printed.

* *Reason for Request to Release Complete Medical Records:*
Review by Specialist, Surgeon, or Therapist Moving From Area Other (Please specify):

Please release the requested records to:

From To
Gwinnett Pediatrics
(Select Address Above)

Please release the requested records:
From To
Practice Name _____

Address: _____

_____

Phone: _____Fax:_____

* Records that contain more than 10 pages will not be faxed for the safety of patient privacy.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. Gwinnett Pediatrics and Adolescent Medicine shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

_____ _____ _____
Signature of Patient or Legal Guardian Printed Name of Signing Party Today's Date

Relationship to patient _____ if relationship is other than parent, documentation of legal authorization(s) or Guardianship must be attached.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The Privacy Act requires that you be informed of your rights to patient privacy. In order to demonstrate that you were advised of your right to privacy of your medical records, we ask that you complete the following:

I, _____ (Legal Guardian's Name) am the responsible party for

Child's Name_____ Date of Birth_____

I am related to the child by _____ (Indicate Relationship).

Please list who **IS NOT ALLOWED** to have access to your child's financial and medical history:

_____

1. Offered (but refused to read/sign) _____ (check here**) –or--,**
2. Reviewed _____, (check here), **--or--**
3. Received (for take-home)_____ (check here),

A copy of GWINNETT PEDIATRICS & ADOLESCENT MEDICINE's Notice of Privacy Practices.

Lab Results:

May we leave your child's lab results on your voicemail? Yes___ No___

If yes, what telephone number should we leave the results on?_____

Date: _____ Signature: _____

The American Recovery and Reinvestment Act of 2009 requires that we gather additional information from you about your background. Thank you for answering the following 3 questions:

Race:

Unknown African American Asian Caucasian Filipino Hispanic
Japanese Chinese Native American Native Hawaiian
Pacific Islander Other

Ethnicity:

Hispanic Non-Hispanic Unknown/Decline

Primary Language:

English Spanish Other Unknown/Decline

How did you hear about our office?

Website Friend Ad Facebook Festival Other

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

PATIENT REGISTRATION INFORMATION

Date_____ **Patient Acct #**_____

PATIENT INFORMATION

Name:_____
First **Middle Initial** **Last**

Date of Birth:_____ **Sex:** □ Male □ Female

Address:_____ **City, State, Zip:**_____

Home Phone:_____ **Mom Work Phone:**_____ **Mom's Cell:**_____

Dad's Work Phone:_____ **Dad's Cell:**_____

Email Address:_____
(We send out appointment notices via email) ***We can text appointment reminders.***

GUARANTOR INFORMATION *(Responsible Party / Will be SELF if patient is 18 yrs or older)*

Name:_____
First **Middle Initial** **Last**

Date of Birth:_____ **Sex:** □ Male □ Female **Social Security#:**_____

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Other** **Relation:**_____

Address:_____ **City, State, Zip:**_____

EMERGENCY CONTACTS

Emergency Contact Name:_____ **Relation:**_____

Phone #1:_____ **Phone #2:**_____

Nearest Relative (not living with you):_____ **Relation:**_____

Phone #1:_____ **Phone #2:**_____

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Address:_____ **City, State, Zip:**_____

Insurance Phone #:_____ **Effective Date:**_____

Policy Holder Name:_____ **Group #**:_____**Patient ID#:**_____

Relationship to Patient:_____ **Birthdate**:_____**Social Security #:**_____

Name & Address of Employer_____

Your signature below indicates your consent for treatment of /as patient and responsibility for the payment of the bill. Thank you.

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Child's Name_____ Date of Birth_____

I am related to the child by _____ (Indicate Relationship).

Please list who **IS NOT ALLOWED** to have access to your child's financial and medical history:

_____

1. Offered (but refused to read/sign) _____ (check here**) –or--,**
2. Reviewed _____, (check here), **--or--**
3. Received (for take-home)_____ (check here),

A copy of GWINNETT PEDIATRICS & ADOLESCENT MEDICINE's Notice of Privacy Practices.

Lab Results:

May we leave your child's lab results on your voicemail? Yes___ No___

If yes, what telephone number should we leave the results on?_____

Date: _____ Signature: _____

The American Recovery and Reinvestment Act of 2009 requires that we gather additional information from you about your background. Thank you for answering the following 3 questions:

Race:

Unknown	African American	Asian	Caucasian	Filipino	Hispanic
Japanese	Chinese	Native American		Native Hawaiian	
Pacific Islander		Indian	Other		

Ethnicity:

Hispanic	Non-Hispanic	Unknown/Decline

Primary Language:

English	Spanish	Other	Unknown/Decline

How did you hear about our office?

Website	Friend	Ad	Facebook	Festival	Other

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

WALK IN POLICY

Our primary concern is the safe, efficient delivery of medical care for all of our patients. We do not have "Walk In Hours". We have many resources for you to schedule appointments. You can call, e-mail, or download our Itune app. Please check out our website at gwinnettpeds.com and click on the Sun.

We see our patients by appointment and do our best within the limits of circumstances that we can control, to see our patients on time. We feel that patients deserve our attention during the appointment time we have reserved for them. We do not encourage walk in appointments, as it interferes with our ability to deliver safe medical care in a timely manner to all our patients. We request that all patients call for an appointment time before coming to our offices.

There are very rare instances in which it is appropriate to come in before calling. A life threatening or potentially life-threatening situation is not one of these instances**. Anytime that a parent feels that a life threatening medical condition is present, the appropriate course of action is to immediately call 911.** EMT's responding can assess the situation and provide emergency care and transport the patient to an Emergency Room for further evaluation. It is NOT appropriate to come to the office in such situations. This will needlessly delay adequate medical evaluation and treatment and may put your child in a dangerous situation.

If you arrive at our office without an appointment, we will have our staff assess your child and determine the degree of urgency of your child's illness.

We will triage your child to an appropriate appointment time. You may be asked to return at another time or day. If we feel that the most appropriate and safest course of action is to have your child evaluated and/or treated in an emergency room, we will refer you accordingly.

We ask that all our patients abide by this and all of our office policies. Chronically ignoring or failing to follow our office policies may result in our requesting that you find another pediatric group for your child's healthcare.

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

LATE ARRIVALS

Our primary concern is the safe, efficient delivery of medical care for all our patients. We have set “Appointment Times” for our patients and do our best within the limits of circumstances that we can control to see our patients on time. Please understand that this policy is in place to prevent the Doctors from falling extremely behind during the day. We ask all out parents to abide by this and all of our office policies. Chronically ignoring or failing to follow our office policies may result in our requesting that you find another pediatric group for your child’s healthcare.

We encourage and expect our patients to arrive in a timely manner as late arrivals interfere with the Doctor being able to stay on his/her schedule.

We feel that patients deserve our attention during the appointment time we have reserved for them. If you arrive late for an appointment, out staff will check with the Doctor to see if we will be able to see you at this time, at a later time during that day, or the next available appointment.

Thank you for helping us to maintain an efficient patient schedule.

Gwinnett Pediatrics & Adolescent Medicine

NEW PATIENT HISTORY FORM

Date _____

Name _____ DOB: _____

How were you referred to our practice? _____

Current problems/Concerns _____

Allergies (Medications, Vaccines, Food, others) _____

Current Medications _____

BIRTH HISTORY

Was this child? Full term _____ Pre-term _____ Adopted _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? Vaginal _____C-section _____ If C-section, why? _____

Any problems during the newborn period? _____

Birth weight _____ Breech? Yes _____ No _____

Passed hearing screen? _____ Passed newborn metabolic screen (PKU)? _____

CHILD'S PAST MEDICAL HISTORY	Yes	No
Any Hospitalizations?	☐	☐
Any Surgeries?	☐	☐
Any Emergency room or urgent care visits?	☐	☐

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

ADHD/ADD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Seizures	☐	☐
Heart Murmur	☐	☐
Wheezing	☐	☐
Pneumonia	☐	☐
Ear Infections	☐	☐
Chicken Pox	☐	☐
Urinary tract infection	☐	☐
Acne	☐	☐
Serious injury or concussion	☐	☐
Developmental and/or speech problems	☐	☐
For girls only, has she started her menstrual cycle?	☐	☐

Other history of chronic problem? _____

Has your child ever been seen by a specialist? _____ If so, please describe?

_____

HAS YOUR CHILD EVER HAD:

	Yes	No
Fainting during or after exercise, emotion or startle?	☐	☐
Extreme shortness of breath with exercise?	☐	☐
Discomfort, pain, or pressure in chest during exercise?	☐	☐

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early heart attack (under 50 yrs. old)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome (PCOS)	☐	☐	☐	☐
Ear tubes	☐	☐	☐	☐
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

SOCIAL HISTORY

Who lives in your child's home?

_____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

Is your child in: Daycare? _____ School? _____ If so, what grade? _____
Does anyone in the house smoke? _____
If there are guns in the home, are they locked/secured? _____
Do you have any concerns about your child's school performance?_____
_____
Do you have any special concerns about your child? _____

_____

Is there anything more you would like us to know about your child?

_____

Form completed by: _____ Relationship to child_____

NEWBORN HISTORY FORM

Date _____

Name _____ D.O.B. _____

Welcome to Gwinnett Pediatrics and Adolescent Medicine. We are pleased you have chosen us to care for your baby. Who may we thank for referring you? _____

BIRTH HISTORY

Was your baby full term? _____ Pre-term? _____ Adopted? _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery: Vaginal _____ C-Section _____

If C-Section please explain why: _____

Please describe any problems after birth: _____

Were there any problems during pregnancy? _____

Was your baby exposed to tobacco, alcohol, or drugs during pregnancy? _____

Did your baby pass the hearing screen in the hospital? Yes _____ No _____

Did your baby have a metabolic screen done(PKU)? Yes _____ No _____

Was your baby breech anytime in the last month of pregnancy? Yes _____ No _____

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early heart attack (under 50 yrs old)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome	☐	☐	☐	☐
Ear tubes	☐	☐	☐	☐

Name:_____

Condition	Mother	Father	Sibling	Grandparent
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

SOCIAL HISTORY

Who lives in your child's home? _____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

Does anyone who cares for the baby smoke? Yes _____ No _____

If there are guns in the home, are they locked/secured? Yes _____ No _____

Will your child be in daycare? Yes _____ No _____

Have both parents had the Adacel vaccine (whooping cough)? Yes _____ No _____