

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.

Guardian or Patient Signature

Date: _____

If No, please explain:

Did the baby pass the hearing screen completed at the hospital? _____ No _____ Yes

Was the baby born at term? _____ No _____ Yes If No, how many weeks? _____

Did baby have metabolic screening done? (PKU testing) _____ No _____ Yes

Any abnormalities found? _____ No _____ Yes If Yes, please explain _____

Did mother have any illness or problem with pregnancy? No _____ Yes _____

If Yes, please explain:

During pregnancy did mother smoke: _____ No _____ Yes

Use drugs or medication _____ No _____ Yes If yes, what _____ when _____

Drink Alcohol _____ No _____ Yes

CHILDS PAST MEDICAL HISTORY

Has your child had any surgery? _____ No _____ Yes Explain: _____

Has your child ever been hospitalized? _____ No _____ Yes Explain _____

Is your child allergic to any medications? _____ No _____ Yes Explain _____

Is your child allergic to any foods? _____ No _____ Yes Explain _____

Has your child been seen by a specialist? _____ No _____ Yes When _____ Who _____

Does your child have or has he/she ever had any of the following:

Frequent ear infection _____ No _____ Yes Explain _____

Problems with ears or hearing _____ No _____ Yes Explain _____

Asthma /wheezing _____ No _____ Yes Explain _____

Bronchitis _____ No _____ Yes Explain _____

Pneumonia _____ No _____ Yes Explain _____

Nasal allergies _____ No _____ Yes Explain _____

Any heart problem or heart murmur _____ No _____ Yes Explain _____

Anemia _____ No _____ Yes Explain _____

Bleeding disorder _____ No _____ Yes Explain _____

Blood transfusion _____ No _____ Yes Explain _____

Frequent abdominal pain _____ No _____ Yes Explain _____

Constipation requiring doctors visits ____ No ____ Yes Explain _____

Bladder or kidney infection ____ No ____ Yes Explain _____

Bed-wetting (after 5 years of age) ____ No ____ Yes Explain _____

Any chronic or recurrent skin problems ____ No ____ Yes Explain _____
(Acne, eczema, etc)

Seizures ____ No ____ Yes Explain _____

Thyroid or other endocrine problems ____ No ____ Yes Explain _____

Diabetes ____ No ____ Yes Explain _____

Use of alcohol or drugs ____ No ____ Yes Explain _____

Celiac disease ____ No ____ Yes Explain _____

Concussion/Head injury ____ No ____ Yes Explain _____

Any other significant problems ____ No ____ Yes Explain _____

FOR GIRLS ONLY

Has she started a menstrual cycle? ____ No ____ Yes Explain _____

Are there problems with her periods? ____ No ____ Yes Explain _____

CURRENT MEDICATION

_____	_____
Name of Medication	Dosage

_____	_____
Name of Medication	Dosage

_____	_____
Name of Medication	Dosage

ACADEMIC HISTORY

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Does your child have an IEP? _____

DEVELOPMENTAL HISTORY

Do you have any concerns about your child's development? ____ No ____ Yes Explain _____

Has you child had speech therapy? ____ No ____ Yes Explain _____

Has your child has physical therapy? ____ No ____ Yes Explain _____

Has your child had occupational therapy? ____ No ____ Yes Explain _____

FAMILY HISTORY

Have any family members had the following:

Deafness ____ No ____ Yes Who _____ Comments _____

Allergies ____ No ____ Yes Who _____ Comments _____

Asthma ____ No ____ Yes Who _____ Comments _____

Tuberculosis ____ No ____ Yes Who _____ Comments _____

Heart Disease ____ No ____ Yes Who _____ Comments _____

High blood pressure ____ No ____ Yes Who _____ Comments _____

High Cholesterol ____ No ____ Yes Who _____ Comments _____

Anemia ____ No ____ Yes Who _____ Comments _____

Bleeding Disorder ____ No ____ Yes Who _____ Comments _____

Liver Disease ____ No ____ Yes Who _____ Comments _____

Kidney Disease ____ No ____ Yes Who _____ Comments _____

Diabetes ____ No ____ Yes Who _____ Comments _____

Bed-wetting ____ No ____ Yes Who _____ Comments _____

Epilepsy or convulsion ____ No ____ Yes Who _____ Comments _____

Alcohol abuse ____ No ____ Yes Who _____ Comments _____

Drug abuse ____ No ____ Yes Who _____ Comments _____

Mental illness ____ No ____ Yes Who _____ Comments _____

Mental retardation ____ No ____ Yes Who _____ Comments _____

Immune problems ____ No ____ Yes Who _____ Comments _____

Celiac disease ____ No ____ Yes Who _____ Comments _____

Prolonged QT Syndrome ____ No ____ Yes Who _____ Comments _____

Has anyone in your family died suddenly under the age 50 ____ No ____ Yes Who _____

Autism ____ No ____ Yes Who _____ Comments _____

HIV/AIDS ____ No ____ Yes Who _____ Comments _____

SOCIAL HISTORY

Does any of your family member or caregiver smoke? ____ No ____ Yes

Is your child in daycare? ____ No ____ Yes

Are there any guns in the home? ____ No ____ Yes

Are there any pets in the home? ____ No ____ Yes If yes, type: _____

Name: _____

Date of Birth: _____

Newborn History Form

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

BIRTH HISTORY:

1. Was your baby full term? YES NO
If no, how many weeks premature? _____
2. Did you have a vaginal or cesarean delivery? _____
If cesarean, please explain why: _____
3. Please describe any problems your baby had right after birth:
NONE _____
4. Did mom have any medical problems during pregnancy? YES NO
If yes, please describe: _____
5. Was your child exposed to tobacco, drugs or alcohol during pregnancy? YES NO
If yes, please describe: _____
6. Did your baby pass the **HEARING** screen in the hospital? YES NO
7. Was your baby born **BREECH** (not head first)? YES NO

FAMILY HISTORY:

Please circle YES if any family members have the following:

High cholesterol >240mg/dl	YES	NO	Who _____	Comments _____
Heart disease or stroke <55yrs old	YES	NO	Who _____	Comments _____
High blood pressure	YES	NO	Who _____	Comments _____
Sudden unexplained death <50yrs	YES	NO	Who _____	Comments _____
Allergies	YES	NO	Who _____	Comments _____
Anemia or Blood disorder	YES	NO	Who _____	Comments _____
Cancer	YES	NO	Who _____	Comments _____
Deafness	YES	NO	Who _____	Comments _____
Diabetes	YES	NO	Who _____	Comments _____
Diabetes/ Thyroid disease	YES	NO	Who _____	Comments _____
Recurrent ear infections/ear tubes	YES	NO	Who _____	Comments _____
Celiac or GI disease, reflux	YES	NO	Who _____	Comments _____
Mental illness/Depression/Anxiety	YES	NO	Who _____	Comments _____
Tuberculosis	YES	NO	Who _____	Comments _____
Seizures/epilepsy/migraines	YES	NO	Who _____	Comments _____
Mental retardation/Autism	YES	NO	Who _____	Comments _____
HIV/AIDS	YES	NO	Who _____	Comments _____
Drug or alcohol abuse	YES	NO	Who _____	Comments _____
Asthma or Wheezing	YES	NO	Who _____	Comments _____
Liver or kidney disease	YES	NO	Who _____	Comments _____

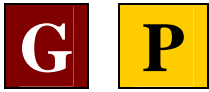
SOCIAL HISTORY:

Who lives in your home? _____

Does anyone who cares for the baby smoke? YES NO If yes, who? _____

Are there pets in the home? YES NO _____

If there are guns in the home, are they locked/secured? YES NO



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) | Chart Notes |
| Patient Summary of all visits | Consultation Notes |
| Immunizations Only | Other: _____ |
| Radiology/ EKG/ Lab Reports | |

****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:

<p>From To Gwinnett Pediatrics (Select Address Above)</p>	<p>Please release the requested records: From To Practice Name _____ Address: _____ _____ Phone: _____ Fax: _____</p>
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*** 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
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Primary Language:

English	Spanish	Other	Unknown/Decline
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How did you hear about our office?

Website	Friend	Ad	Facebook	Festival	Other
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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: _____

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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 #: _____

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Date: _____

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: _____

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Pacific Islander		Indian	Other		

Ethnicity:

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Primary Language:

English	Spanish	Other	Unknown/Decline
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How did you hear about our office?

Website	Friend	Ad	Facebook	Festival	Other
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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 our 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, our 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



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.



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Gwinnett Pediatrics & Adolescent Medicine



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 any set “Walk in Hours”.

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 of our patients. To that end, we request that all patients call for an appointment time before coming to our offices.

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