

# Pediatric Associates

Jeff O. Elder, MD, FAAP  
Jennifer W. Gottsman, MD, FAAP  
Erol Onal, DO, FAAP  
S. Finch, MD, FAAP  
Kelly M. Lathem, MD, FAAP

Kevin R. Johnson, MD, FAAP  
Brenda B. Surlles, MD, FAAP  
Michael E. Hilton, MD, FAAP Cathryn  
Susan F. Carey, MD, FAAP  
Kristi A. Kennedy, PNP

## New Patient Registration

### Required

Name

Last:

First:

Middle:

Nickname:

Gender

Male  Female (required)

Date of Birth (mm/dd/yyyy)

Street Name and Number

### Patient Demographics

City, State and ZIP Code

Home Phone

Emergency Contact Name

Emergency Contact Phone Number

Living Arrangements

Both biological parents  Biological mother only  Biological father only  Other relative

Foster parent(s)  Adoptive parent(s)  Other / Not listed Other:

Mother Name

Mother DOB

Mother Cell Phone

Employed   
  Student   
  Retired   
  Unemployed

Mother Employment Status  
 Other / Not listed   
 Other:

Mother Employer

Mother Work Phone

Father Name

Father DOB

Father Cell Phone

Employed   
  Student   
  Retired   
  Unemployed

Father Employment Status  
 Other / Not listed   
 Other:

Father Employer

Father Work Phone

### Insurance

Health Insurance Coverage?   
 Yes   
 No

Does the Patient have their insurance information with them today? (i.e. health insurance card)   
 Yes   
 No

### Primary Insurance

Aetna   
 Amerigroup / Wellcare   
 Blue Cross Blue Shield   
 Cigna

Coventry Health Care of Georgia   
 Great-West Healthcare   
 Humana   
 Kaiser POS Plan of Georgia

Medicaid / Peachcare   
 United Healthcare   
 Other:

Primary Policy ID Number

Primary Policy Group Number

Name of Primary Policy Holder

Relationship to Primary Policy Holder   
 Child   
 Other:

DOB of Primary Policy Holder

Gender of Primary Policy Holder   
 Male   
 Female

SSN of Primary Policy Holder

## Secondary Insurance

Secondary Health Insurance Coverage  Yes  No

Secondary Insurance Provider

<input type="checkbox"/> Aetna	<input type="checkbox"/> Amerigroup / Wellcare	<input type="checkbox"/> Blue Cross Blue Shield	<input type="checkbox"/> Cigna
<input type="checkbox"/> Coventry Health Care of Georgia	<input type="checkbox"/> Great-West Healthcare	<input type="checkbox"/> Humana	<input type="checkbox"/> Kaiser POS Plan of Georgia
<input type="checkbox"/> Medicaid / Peachcare	<input type="checkbox"/> United Healthcare	Other: <input style="width: 100px;" type="text"/>	

Secondary Policy ID Number

Secondary Policy Group Number

Name of Secondary Policy Holder

Relationship to Secondary Policy Holder  Child  Other

DOB of Secondary Policy Holder

Gender of Secondary Policy Holder  Male  Female

## Past Medical History

Pediatric Past and Current Medical Conditions

<input type="checkbox"/> Acid Reflux / GERD	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma / Allergies	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Developmental Concerns	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Heart Defects / Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease / Hepatitis	<input type="checkbox"/> Mumps / Measles	<input type="checkbox"/> Obesity / Eating Disorder	<input type="checkbox"/> Physical / Emotional / Sexual Abuse
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Seizures / Epilepsy
<input type="checkbox"/> Skin Problems / Eczema	<input type="checkbox"/> TB / Lung Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Urinary Infections
<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Other / Not Listed	<input type="checkbox"/> None	

Other Conditions Treated For

## Medication/Supplement Use

Is patient on Medications?  Yes  No List Medication(s):

## Pregnancy & Birth

Mother's Problems at Birth	<input type="checkbox"/> Fever	<input type="checkbox"/> Flu	<input type="checkbox"/> Spotting / Bleeding	<input type="checkbox"/> Kidney Infections
	<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Swelling of Hands / Feet	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Dizzy Spells
	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Headaches	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Vomiting

Premature  Yes  No Other:

Birth Weight  pounds  
 ounces

Problems at Birth	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Infections	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other / Not listed
	<input type="checkbox"/> None	<input type="checkbox"/> I don't know		

Breastfeed or Bottle	<input type="checkbox"/> Breastfeed	<input type="checkbox"/> Bottle	<input type="checkbox"/> Both	<input type="checkbox"/> Other / Not listed
	Other: <input type="text"/>			

Unusual Feeding Habits  Yes  No Other:

Appetite  Yes  No Other:

Disagree with Food  Yes  No Other:

**Family History**

Family Medical History Condition List	<input type="checkbox"/> Acid Reflux / GERD	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Osteoporosis
	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Psychiatric Conditions	<input type="checkbox"/> Seizures / Epilepsy	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other / Not Listed	<input type="checkbox"/> None	

**Patient Privacy**

I ACKNOWLEDGE BY SIGNING THAT I HAVE RECEIVED: THE NOTICE OF PRIVACY PRACTICES AND NOTICE OF INDIVIDUAL RIGHTS. I AUTHORIZE PEDIATRIC ASSOCIATES TO PROVIDE MEDICAL CARE TO MY CHILDS (REN). I ALSO AUTHORIZE PEDIATRIC ASSOCIATES TO FURNISH MY CHILD'S IMMUNIZATION INFORMATION TO MEDICAL FACILITIES, SCHOOLS, AND DAYCARES. BY SIGNING BELOW, I HEREBY CONSENT FOR PEDIATRIC ASSOCIATES TO USE OR DISCLOSE INFORMATION ABOUT MY CHILD(REN) (OR ANOTHER PERSON FOR WHOM I HAVE THE AUTHORITY TO SIGN) THAT IS PROTECTED UNDER FEDERAL LAW, FOR THE SOLE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU MAY REFUSE TO SIGN THE CONSENT FORM. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Guardian Signature:  DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

