

# PEDIATRIC ASSOCIATES

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**PLEASE PRINT AND RETURN TO THE FRONT DESK WHEN COMPLETED**

Child's Full Name: \_\_\_\_\_  
 Nickname OR name most frequently called: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name of Sibling's seen by Pediatric Associates: \_\_\_\_\_  
 Your Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State:(other than GA) \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer's Name (Mother or Father) \_\_\_\_\_ Father \_\_\_\_\_  
 Work Phone: Mother \_\_\_\_\_  
 Name and phone number of emergency contact: \_\_\_\_\_

Child's Health Insurance Carrier: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Group Name: \_\_\_\_\_  
 Insured's ID #: \_\_\_\_\_ Group # \_\_\_\_\_

**ARE BOTH SICK AND WELL VISITS COVERED? Well Sick Both**

**Child's Medical History – To be Completed by the Parent:**

**PREGNANCY AND BIRTH:**

- Did the Mother have illness during pregnancy? Yes No  
 - Was the baby born on time? Yes No  
 - What was the birth weight? \_\_\_\_\_

**FEEDING AND DIGESTION:**

- Did the baby have any problems while in the hospital? Yes No  
 - Any unusual feeding problems during the first year? Yes No  
 - Is your child's appetite usually good? Yes No  
 - Do any foods seem to disagree with the child? Yes No  
 - Does the child often have diarrhea? Yes No  
 - Does the child have frequent constipation? Yes No  
 - Does the child take daily vitamins? Yes No  
 - Does the family drink well water? Yes No  
 - Is the infant on formula or breast milk, if formula, which one? \_\_\_\_\_

**FAMILY HISTORY:**

- Circle any of the following diseases that this child's parents, grandparents, or other relatives have had: tuberculosis, diabetes, asthma, allergy, hay fever, seizures, inherited diseases or heart disease under age 50.  
 - Are the child's parents in good health? Yes No  
 - Are the child's siblings in good health? Yes No  
 - Have any of your children died? Yes No

**INFECTIONS, ILLNESSES, AND MISCELLANEOUS PROBLEMS:**

- Has your child had more than 3 ear infections? Yes No  
 - Does your child usually have more than 3 colds a year with fever? Yes No  
 - Does your child have more than 3 throat infections a year? Yes No  
 - Does your child have trouble with urination? Yes No  
 - Has your child ever had a seizure? Yes No  
 - Does your child have trouble with hearing? Yes No  
 - Does your child have trouble with vision? Yes No  
 - Does your child have trouble sleeping? Yes No  
 - Has your child missed any vaccinations? Yes No  
 - List surgeries: \_\_\_\_\_

- List hospitalizations: \_\_\_\_\_

**ALLERGIES:**

- Has your child ever had hives? Yes No  
 - Has your child ever had eczema? Yes No  
 - Has your child ever been diagnosed with asthma? Yes No  
 - Does your child tend to have a stuffy nose or "constant cold"? Yes No  
 - Has your child had reactions or allergies to any kind of medicine? Yes No

**BEHAVIORAL:**

- Does your child do well in school? Yes No  
 - Does your child get along with other children? Yes No

**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 CHILD'S (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.**

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_