

Patient Registration- Required Yearly

Patient Information (Please list all children in the family and use legal name)

Patient Name: _____ D.O.B. _____ Sex: Male / Female
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 Patient Name: _____ D.O.B. _____ Sex: Male / Female
 Patient Name: _____ D.O.B. _____ Sex: Male/Female

Address: _____ City: _____ Zip: _____

Parental/ Guardian information

Mother's Name _____ D.O.B. ____/____/____
 Home# _____ Cell# _____ Email _____
 Address (If different from child) _____
 Place of Employment _____ Occupation/Title _____

Father's Name _____ D.O.B. ____/____/____
 Home# _____ Cell# _____ Email _____
 Address (If different from child) _____
 Place of Employment _____ Occupation/Title _____

If parents are divorced or separated please fill out this section:

Who has physical custody? _____
 Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No
 If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Primary Insurance information

Name (Policy Holder) _____ D.O.B. (Policy Holder) _____
 Address of policy holder if other than listed above _____
 *Relationship to Patient _____ Insurance company _____
 Member ID: _____ Group #: _____

Secondary Insurance Yes No

Effective August 6, 2018 for patients with high deductible insurance plans

If you have a high deductible plan, at each sick visit we will collect a \$50 deposit for each child seen. This is to help offset your remaining patient payments applied by your insurance plan once your claim has been processed. You will receive a statement for any additional deductible amounts applied by your insurance plan once your claim has been processed.

Emergency contact: (other than parents) Name: _____ phone: _____

Please select a pharmacy:

CVS- Woodlawn 1099 Johnson Ferry (770) 973-1810
 CVS- Lower Roswell 687 Johnson Ferry Rd (770) 977-9220
 CVS- Next to Trader Joe's 4250 Roswell Rd (770) 565-4064
 Publix- 1100 Johnson Ferry Rd (770) 509-2350
 Other: _____

In order to provide the best care for your child/children, we will at some visits ask you to fill out questionnaires on your child's development/behavior/symptoms. These forms are screening tools. These screenings may or may not be completely covered by your insurance company. If they are not covered, the cost would be minimal. They are necessary for us to provide adequate care.

Financial/Privacy Policies (HIPAA)

_____ (Initial) I authorize East Cobb Pediatrics and Adolescent Medicine to treat the above named child.
 _____ (Initial) I authorize release of medical and billing information to the insurance company so that payment for charges can be processed.
 _____ (Initial) I authorize and direct the insurance company to pay the portion of charges due to EC Pediatrics.
 _____ (Initial) I acknowledge that a copy of the East Cobb Pediatrics and Adolescent Medicine Financial Policy and Privacy Policies have been made available.

FORM COMPLETED BY: MOM STEP-MOM DAD STEP-DAD OTHER _____

Signature _____ Date ____/____/2018

PRINT NAME _____

 Internal Use Only: Parent/Guardian refused to complete profile. Presented on (date&time): _____ by (name) _____

Consent for Protected Health Information

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

How would you like to be reminded of appointments? (number/email address listed in below section will be used)

- Voice Mail Text Message E-mail

By initialing below you are consenting to East Cobb Pediatrics leaving protected health information on the listed forms of unsecure communication. (Protected health information examples may include -reminders for appointments, emailed copies of physical/camp/sports forms, copies of behavioral/mental health and other records, texts corresponding with providers, etc.) This consent applies to correspondence being sent or received by East Cobb Pediatrics.

____ (initial) Voice Mail - (____) _____ -- _____

____ (initial) Text Message - same number as above or (____) _____ -- _____

____ (initial) Email- _____

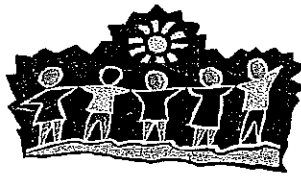
This request to receive emails and/or text messages will apply to any information I request or correspondence needed regarding health information unless I request a change in writing.

Signature: _____ Date: _____

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction.

We now offer electronic statements!

Look out for our new statements! They will now have a code that allows you to do quick pay. With quick pay you can easily go online, without setting up an account, and pay your bill. If you take a couple seconds longer and set up an account, you will also be able to select electronic statements, as well as have your payment history at your fingertips. It makes getting year end statements a breeze. We hope you will take advantage of this great new service.



**UPDATED PATIENT
FAMILY HISTORY**

**EAST COBB PEDIATRICS
& ADOLESCENT MEDICINE**

PATIENT NAME: _____ **DOB:** _____ **TODAY'S DATE:** _____

Since your last visit, has anyone in the family died? If so, how is this family member related to your child? How old were they when they died? What was the cause of death?

Since your last visit, are there any individuals in the extended family including brothers, sisters, parents, grandparents, aunts, uncles, or cousins who have been born and have or are newly diagnosed with any of the following? If so, list how that individual is related to your child.

- Organ failure (heart failure, liver failure) prior to age 40

- Developmental delay, intellectual disability, autism spectrum disorder

- Seizures

- Birth defects (examples: congenital heart disease, spina bifida, extra or missing fingers, clubfeet)

- Facial features that look different from other family members

- Congenital deafness (born deaf)

- Blindness

- Multiple handicaps

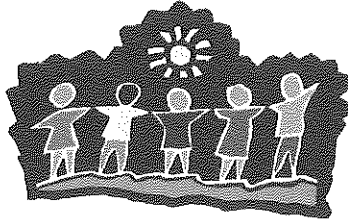
- Known genetic disorder

Have there been any changes to your child's health since their last check up? Any surgeries, hospitalizations or new allergies?

Parent Signature _____

East Cobb Pediatrics & Adolescent Medicine, P.C.

Marisa Gadea, M.D.
Elizabeth Kemp, M.D.
Karen Thrower, M.D.
Amanda McGahee, M.D.
Padma Iyengar, M.D.
Daniel Heine, M.D.



Tracy Barr, M.D.
Sharon Lebedin, CPNP
Deanna Fetsch, CPNP
Barbara Cossman, CPNP
Shelly Brown, CPNP

Authorization and Consent for Medical Treatment of a Minor Child

I, the undersigned parent or legal guardian of minor child/children

Patient name: _____ DOB: _____
Patient name: _____ DOB: _____
Patient name: _____ DOB: _____
Patient name: _____ DOB: _____

By this written authorization do hereby authorize and give my consent to East Cobb Pediatrics, it's physicians and their authorized personnel to evaluate and administer medical treatment to my child in those situations indicated by me below where I am not physically present with my child/children.

As initialed below to indicate my consent and /or delegation of my authority to consent to the medical evaluation, diagnosis and treatment of my child/children, I agree to and hereby authorize the following actions by ECP until such time as I revoke in writing the authorization and consents listed below:

_____ I hereby authorize ECP to see, examine, evaluate and treat (including administration of immunizations and/or lab work) my child, in accordance with the personal requests of my child's caregiver, if I am not present, in accordance with the consent communicated by the below individual/individuals to ECP pursuant to the delegation of my authority granted here, and consistent with the Physicians' professional judgement of my child's medical needs. Authorized Caregiver/Caregivers (other than parents). Caregiver must be able to provide valid picture identification.

Authorized Persons Name: _____
Authorized Persons Name: _____
Authorized Persons Name: _____
Authorized Persons Name: _____

_____ No one other than parents will be bringing patient in for treatment

FOR CHILDREN 16 YEARS OF AGE OR OLDER:

_____ I hereby authorize ECP to see, examine, evaluate and treat my child in accordance with my child's personal requests if I am not present, consistent with the Physicians' professional judgement of my child's medical needs.

Parent/Legal Guardian Name (printed)

Date

Signature of Parent/Legal Guardian

Note: If you are acting in the capacity as a court ordered and appointed legal guardian, kindly supply us with a certified copy of the guardianship order evidencing such authority.

Marietta: 1121 Johnson Ferry Road, Suite 220, Marietta, GA 30068 ph: 770-977-0094 fax: 770-509-9463
Kennesaw: 6110 Pine Mountain Road, Suite 202, Kennesaw, GA 30152 ph: 770-795-4553 fax: 770-795-4513

Visit us on the web: www.eastcobbped.com