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

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

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

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

Address: _____ **City:** _____ **Zip:** _____

How would you like to be reminded of your appointments?

Phone# _____ *text#* _____ *email* _____

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**

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.

_____ (Initial) I authorize EC Pediatrics to leave voice mail messages containing protected healthcare information at the following numbers: (H) _____ (Other) _____

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

Signature _____ Date ____/____/____

PRINT NAME _____

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.

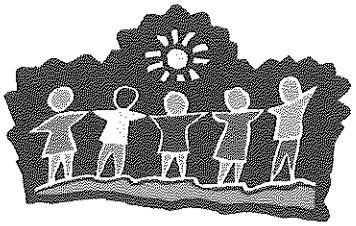
- Organ failure (heart failure, liver failure) prior to age 40
- Developmental delay, intellectual disability, autism spectrum disorder
- Seizures
- Birth defects (examples: congenital heart disease, spina bifida, extra or missing fingers, clubfeet)
- Facial features that look different from other family 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 herby 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.eastcobbpeds.com