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:** _____

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 for us to electronically send your prescriptions when available:

☐ Walgreens	☐ CVS	☐ Kroger Shiloh Square	☐ Publix- Cobb Pkwy	☐ Other
2779 Cobb Pkwy	2782 N. Cobb Pkwy	3895 Cherokee St	2774 N. Cobb Pkwy	
Kennesaw 30152	Kennesaw 30144	Kennesaw 30144	Kennesaw 30152	
770-795-1838	770-420-1092	770-218-7033	770-426-3246	

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 ____/____/____

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.

INITIAL HISTORY

EAST COBB PEDIATRICS &
ADOLESCENT MEDICINE

PATIENT NAME:_____
DATE OF BIRTH:_____
FORM COMPLETED BY:_____

Birth History ☐ **Do not know birth history** ☐ **Adopted**

Birth weight_____ Were there any prenatal or neonatal complications? _____
If yes, explain _____
Was the delivery ☐Vaginal ☐Cesarean If cesarean, why?_____
_____

Did you deny any medical treatment at the hospital? ☐Yes ☐No If yes, explain _____
_____

During pregnancy, did mother:
Use tobacco ☐Yes ☐No Drink alcohol ☐Yes ☐No
Use drugs or medications ☐Yes ☐No IF answered yes, what drugs/medications were used:
_____

General **DK = Don't Know**

Do you consider your child to be in good health? ☐Yes ☐No ☐DK
Explain_____
_____

Does you child have any serious illnesses or medical conditions? ☐Yes ☐No ☐DK
Explain_____
Has your child had any surgery? ☐Yes ☐No ☐DK
Explain_____
_____

Has your child ever been hospitalized? ☐Yes ☐No ☐DK Explain_____
_____

Is your child allergic to any medications? ☐Yes ☐No ☐DK
Explain_____
_____

Past History DK = Do not know

Does your child have, or has your child ever had: Patient Name: _____

Chickenpox	☐ Yes ☐ No ☐ DK	When _____
Frequent ear infections	☐ Yes ☐ No ☐ DK	Explain _____
Problems with ears or hearing	☐ Yes ☐ No ☐ DK	Explain _____
Allergies (Other than medications)	☐ Yes ☐ No ☐ DK	Explain _____
Problems with eyes or vision	☐ Yes ☐ No ☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No ☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes ☐ No ☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes ☐ No ☐ DK	Explain _____
Blood transfusion	☐ Yes ☐ No ☐ DK	Explain _____
HIV	☐ Yes ☐ No ☐ DK	Explain _____
Organ transplant	☐ Yes ☐ No ☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes ☐ No ☐ DK	Explain _____
Chemotherapy	☐ Yes ☐ No ☐ DK	Explain _____
Frequent abdominal pain	☐ Yes ☐ No ☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes ☐ No ☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes ☐ No ☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes ☐ No ☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes ☐ No ☐ DK	Explain _____
Cancer	☐ Yes ☐ No ☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes ☐ No ☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes ☐ No ☐ DK	Explain _____
Sleep problems: snoring	☐ Yes ☐ No ☐ DK	Explain _____
Chronic or recurrent skin problems (acne, eczema)	☐ Yes ☐ No ☐ DK	Explain _____
Frequent headaches	☐ Yes ☐ No ☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes ☐ No ☐ DK	Explain _____
Obesity	☐ Yes ☐ No ☐ DK	Explain _____
Diabetes	☐ Yes ☐ No ☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes ☐ No ☐ DK	Explain _____
High blood pressure	☐ Yes ☐ No ☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes ☐ No ☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes ☐ No ☐ DK	Explain _____
Tobacco use	☐ Yes ☐ No ☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes ☐ No ☐ DK	Explain _____
Developmental delay	☐ Yes ☐ No ☐ DK	Explain _____
Dental decay	☐ Yes ☐ No ☐ DK	Explain _____
History of family violence	☐ Yes ☐ No ☐ DK	Explain _____
Sexually transmitted infections	☐ Yes ☐ No ☐ DK	Explain _____
Pregnancy	☐ Yes ☐ No ☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes ☐ No ☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age at first period _____

Any other significant problem _____

_____

East Cobb Pediatrics

Please complete this family history form for your children

TODAYS DATE: _____

PATIENT NAME: _____

PATIENT DOB: _____ _____

Put an X for all of your children's biological relatives who have the condition.

CONDITION	Child's Mother	Child's Father	Child's Sister	Child's Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Child's Aunt	Child's Uncle	Child's Cousin
ADHD/ADD											
Asthma											
Autism spectrum disorder, PDD Aspergers											
Birth Defect											
Bleeding or clotting disorder											
Cancer before age 50											
Born with an eye/vision problem											
Born with hearing loss											
Born with a heart problem											
Diabetes											
Early heart disease (<55 in men, <65 in women											
Genetic syndrome or condition											
High blood pressure											
High cholesterol or triglycerides											
Kidney Disease											
Mental or mood disorder											
Obesity											
Seizures											
Sudden cardiac death											
Other condition that affects 2 or more family members											
No information about this relative											
Thyroid Disorders											

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

East Cobb Pediatrics & Adolescent Medicine, P.C.

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.
Please list 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:_____

OR

_____ 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