Athens Kids Specialists
650 Oglethorpe Ave Suite 4
Athens GA 30606
Tel 706-543-9899 / Fax 706-613-3995

Patient Registration

PATIENT INFORMATION (Please list all children who will be patients)

1._____ "(Nickname)_____" DOB:_____/_____/_____ SSN: _____/_____/_____ M / F

2._____ "_____" DOB:_____/_____/_____ SSN: _____/_____/_____ M / F

3._____ "_____" DOB:_____/_____/_____ SSN: _____/_____/_____ M / F

Address: _____ City: _____ Zip: _____

Home Tel.: (_____)_____--_____ Cellphone: (_____)_____--_____

Preferrred Pharmacy:_____ Location: _____ Tel.: (_____)_____--_____

Previous Doctor::_____ Location: _____ Tel.: (_____)_____--_____

PARENT OR GUARDIAN INFORMATION

Name1: _____ Relationship: _____ DOB:_____/_____/_____ SSN: _____/_____/_____

Address (if different) : _____ City: _____ Zip: _____

Home Tel.: (_____)_____--_____ Work Tel.: (_____)_____--_____ Employer: _____

Employer Address: _____ City: _____ Zip: _____

Name2: _____ Relationship: _____ DOB:_____/_____/_____ SSN: _____/_____/_____

Address (if different) : _____ City: _____ Zip: _____

Home Tel.: (_____)_____--_____ Work Tel.: (_____)_____--_____ Employer: _____

Employer Address: _____ City: _____ Zip: _____

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Contact Tel.: (_____)_____--_____

Address (if different) : _____ City: _____ Zip: _____

INSURANCE INFORMATION

[ ] AMERIGROUP [ ] BC/BS [ ] Aetna 1. Member Id: _____

[ ] WELLCARE [ ] AHPS [ ] Medicaid 2. Member Id: _____

[ ] PEACHSTATE [ ] UHC [ ] _____ 3. Member Id: _____

OTHER INFORMATION

How did you hear about us? [ ] Friend [ ] Yellow Pages [ ] Newspaper/Somos La Voz

[ ] Physician [ ] Insurance Directory [ ] Newspaper/Connexiones Latinas

[ ] Internet [ ] Billboard [ ] Sporting Youth

(Important—Please read carefully before signing)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that payment of all medical care is due at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance NOT PAID by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient accounts in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Athens Kids Specialists, PC to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Athens Kids Specialists, PC. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____/_____/_____ Witness: _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I certify that I have read and understood Athens Kids Specialists, PC's privacy practices. I have been given the opportunity to ask questions regarding the Notice and its contents.

Signature: _____ Date: _____/_____/_____ Witness: _____

Athens Kids Specialists, PC
650 Oglethorpe Ave Suite 4
Athens GA 30606
Tel 706-543-9899 / Fax 706-613-3995

Medical Records Request

(Please fill out form completely and return to your child's previous doctor.)

To: Dr._____ _____
(Previous Doctor/***Doctor de Antes***) (Office Tel.)

_____ _____
(Address/***Direccion***) (Office Fax)

_____
(City/State/Zip/***Ciudad/Estado/Codigo Postal***)

Kindly fax or mail copies of medical records of the patients below to:

Athens Kids Specialists, PC
650 Oglethorpe Ave, Suite 4
Athens GA 30606

Tel. 706-543-9899
Fax 706-613-3995

(Patient Name /***Nombre del Paciente***)	(Date of Birth /***Fecha de Nacimiento***)
_____	_____
_____	_____
_____	_____

Thank you very much.

Sincerely,

_____ _____
(Signature of Parent or Guardian/***Firma del padre***) (Date/***Fecha***)

_____
(Printed Name)

Athens Kids Specialists
650 Oglethorpe Ave Suite 4
Athens GA 30606
Tel 706-543-9899 / Fax 706-613-3995

Patient Initial History

Child's Name: _____ DOB:_____/_____/_____ M / F Form Completed by: _____

Household:

Please list all those living in the child's household

Name: _____ Relation: _____ Age: _____ Health Problems: _____
Name: _____ Relation: _____ Age: _____ Health Problems: _____
Name: _____ Relation: _____ Age: _____ Health Problems: _____
Name: _____ Relation: _____ Age: _____ Health Problems: _____
Name: _____ Relation: _____ Age: _____ Health Problems: _____
Name: _____ Relation: _____ Age: _____ Health Problems: _____

Are there siblings that are not listed? If so, please their names, ages, and where they live. _____

_____

If mother and father are not living together, or child does not live with parents, what is child's custody status? _____

_____

If one or both parents are not living in the home, how often does the child get to see them? _____

_____

Birth History:

Birth Weight: _____ lbs Birth Length: _____ in Was child born: [ ] Term [ ] Early [ ] Late? If early, how many weeks gestation? _____ wks

Did the mother have any illness or problems with pregnancy? If yes, please describe. _____

During pregnancy, did mother: Smoke? _____ Drink alcohol? _____ Use drugs? _____

Did the baby have any problems right after birth? If yes, please describe. _____

Did the baby go home with the mother from the hospital? _____ At which hospital was baby born? _____

Was delivery: [ ] Vaginal [ ] Caesarean? Was initial feeding: [ ] Breast [ ] Bottle?

General:

Do you consider your child sickly? _____

Does your child have any serious illness or medical condition? _____

Has your child had serious injuries or accident? What? When? _____

Has your child had any surgery? For what? When?_____

Has your child been hospitalized? For what? When? _____

Is your child allergic to any drugs or medicines? _____

Development:

Please describe any concerns about your child's physical development? _____

Please describe any concerns about your child's mental or emotional development? _____

Please describe any concerns about your child's attention span? _____

Please describe the child's behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resources classes? _____

Child's Name: _____ DOB:_____/_____/_____ M / F Form Completed by: _____

Have any family members had the following:

Deafness: _____

Nasal Allergies: _____

Tuberculosis: _____

Heart Disease (Before 50 years old): _____

High Blood Pressure (Before 50 years old): _____

High Cholesterol: _____

Anemia: _____

Bleeding Disorder: _____

Liver Disease: _____

Kidney Disease: _____

Diabetes (Before 50 years old): _____

Bed-wetting (After 10 years old): _____

Epilepsy or Convulsions: _____

Alcohol Abuse: _____

Drug Abuse: _____

Mental Illness: _____

Mental Retardation: _____

Immune Problems, HIV or AIDS: _____

Does the child have or has he/she ever had:

Chickenpox/Varicella: _____

Frequent ear infections: _____

Problems with ear or hearing: _____

Nasal Allergies: _____

Problems with eyes or vision: _____

Asthma, bronchitis, bronchiolitis, pneumonia: _____

Any heart problems or heart murmur: _____

Anemia or bleeding problem: _____

Blood transfusion: _____

Frequent abdominal pain: _____

Constipation requiring doctor visits: _____

Bladder or kidney infection: _____

Bed-wetting (After age 5): _____

[For GIRLS only] First menstrual period: _____

[For GIRLS only] Any problems with periods: _____

Any chronic or recurrent skin problems: _____

Frequent headaches: _____

Convulsions or other neurologic problems: _____

Diabetes: _____

Thyroid or other endocrine problems: _____

Any other significant problems: _____

Use of alcohol or drugs: _____

Athens Kids Specialists, PC
650 Oglethorpe Ave Suite 4
Athens GA 30606
Tel 706-543-9899 / Fax 706-613-3995

TB & Lead Questionnaire

Tuberculosis Risk Assessment	*Yes*	*No*	*Lead Risk Assessment*	*Yes*	*No*
1. Is the child a close contact of a person with infectious tuberculosis?			1. Does your child live in or often visit a house that may have been built before 1978?		
2. Is the child foreign born (especially Asian, African, Latin American), a refugee or a migrant?			2. Does your child live in or often visit a house that is being remodeled or is having paint removed?		
3. Does the child have HIV infection?			3. Does your child live with or often visit another child that has an elevated blood lead level?		
4. Is the child in contact with an incarcerated person or a person who was incarcerated in the past five years?			4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?		
5. Is the child exposed to anyone infected with HIV?			5. Does your child chew on or eat non- food items like paint chips or dirt?		
6. Is the child exposed any of the following: homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs?			6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?		
7. Is the child in contact with migrant farm workers?			7. Does your child receive medicines such as greta, azarcon, kohl, orpay-loo-ah?		
8. Does the child have a medical condition or treatment or a medical condition which suppresses the immune system?					
9. Does the child live in a community in which it has been established that a high risk exists for tuberculosis?					
10. Has the child traveled out of the country since his last doctor visit?					

Individuals treated for tuberculosis or are currently active should not be tested. Any "yes" answer means the child is at high risk and should receive a tuberculin skin test (Mantoux) which must be read by a health professional and the Public Health Department should be notified.

When using the questionnaire, blood lead tests should be done immediately if the child is at high risk: one or more "yes" or "I don't know" answers on the risk assessment questions above.