Athens Kids Specialists, PC
1500 Oglethorpe Ave, Suite 100
Athens GA 30606
Tel 706-543-9899/Fax 706-613-3995

Patient Registration

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

1. _____ DOB: _____/_____/_____SSN: _____-_____-_____ M / F
2. _____ DOB: _____/_____/_____SSN: _____-_____-_____ M / F
3. _____ DOB: _____/_____/_____SSN: _____-_____-_____ M / F
4. _____ DOB: _____/_____/_____SSN: _____-_____-_____ M / F

Address: _____City:_____Zip_____
Home Tel: (_____) _____-_____ Cell Phone: (_____)_____-_____ Email: _____
Race and Ethnicity? _____
Preferred Pharmacy: _____ Location: _____ Tel: (_____) _____-_____
Previous Doctor: _____ Location: _____ Tel: (_____) _____-_____

PARENT OR GUARDIAN INFORMATION

Name1: _____ Relationship: _____ DOB: _____/_____/_____SSN:_____-____-_____
Address (If different): _____City: _____ Zip: _____
Home Tel: (_____) _____-_____Employer: _____Work Tel: (_____) _____-_____
Employer Address: _____ City: _____ Zip: _____

Name2: _____ Relationship: _____ DOB: _____/_____/_____SSN:_____-____-_____
Address (If different): _____City: _____ Zip: _____
Home Tel: (_____) _____-_____Employer: _____Work Tel: (_____) _____-_____
Employer Address: _____ City: _____ Zip: _____

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ DOB: _____/_____/_____ Tel: _____
Address (If different): _____City: _____ Zip: _____

INSURANCE INFORMATION

Insurance Name: _____ Member ID: _____ Group Number: _____

Insurance Name: _____ Member ID: _____ Group Number: _____

How did you hear about us? _____

(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 Specialist, PC. I permit a copy of this authorization to be use 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.

Signature: _____Date: _____/_____/_____ Witness: _____

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Family History

Form completed by: _____ Date: _____

Please list everyone living in the child's household

Name: _____Relation:_____Age:_____DOB:_____/_____/_____
Name: _____Relation:_____Age:_____DOB:_____/_____/_____
Name: _____Relation:_____Age:_____DOB:_____/_____/_____
Name: _____Relation:_____Age:_____DOB:_____/_____/_____
Name: _____Relation:_____Age:_____DOB:_____/_____/_____
Name: _____Relation:_____Age:_____DOB:_____/_____/_____

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

_____

Are the mother and father: [SINGLE] [MARRIED] [DIVORCED] since: _____ remarried since: _____

(Only if mom and dad do not live together or does not live with parents) Who has custody of the child/children? _____

_____

How often does the child see this parent? _____

_____

Please note the family members that have/had any of the illnesses listed below.

	Yes or No	Who? (Maternal or Paternal?)	Alive or Deceased (when?)
Diabetes before 50			
High blood pressure			
Asthma			
Heart Disease			
Cancer			
Sickle Cell Anemia			
Stroke			
Heart Attack before 50			
High Cholesterol			
Tuberculosis			
Anemia			
Bleeding Disorder			
Liver Disease			
Kidney Disease			
Deafness			
Bed-Wetting after 10			
Epilepsy or Convulsions			
Alcohol Abuse			
Drug Abuse			
Mental Illness			
Mental Retardation			
Immune Issues, HIV or AIDs			
Other:			

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Patient Initial History

Form completed by: _____ Date:_____

Child's Name: _____ DOB:_____/_____/_____

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 during the pregnancy? If yes, please describe. _____

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

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

Did the baby go home with the mother from the hospital? _____. Which hospital was the baby delivered at? _____

Type of delivery: [ ] Vaginal [ ] Caesarean. Was initial feeding: [ ] Breast or [ ] Bottle?

General:

Do you consider your child sickly? If yes, please explain _____

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

Has your child had any surgeries? _____

If yes, please explain what kind and when. _____

Had your child been hospitalized? For what and where? _____

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 any concerns about your 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 resource classes? _____

Social History:

During the day or working hours who watches your child? _____

Are there guns present in the house? _____. If YES, are they in a secure location away from your children? _____

Do you have well water or city water in your household? _____

Home heat type? [ELECTRIC] [FIREPLACE] [NATURAL GAS] [KEROSENE] [PROPANE] [SPACE HEATERS] [WOOD STOVE]

Does anyone who lives with the child smoke? _____;

If YES, list family members that smoke: _____

Where do these family members smoke?[**INSIDE**: (ALWAYS) (SOMETIMES) (NEVER)] [**OUTSIDE**: (ALWAYS) (SOMETIMES) (NEVER)]

Does the child live in an: [APARTMENT] [HOUSE] [MOBILE HOME]

List any pets, and if they are kept inside or outside of the home: _____

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Patient Initial History

Form completed by:_____ Date:_____

Child's Name: _____ DOB:_____/_____/_____

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

Chickenpox/ Varicella: _____
Frequent ear infection: _____
Problems with ear or hearing: _____
Nasal Allergies: _____
Problems with eyes or vision: _____
Asthma, bronchitis, bronchiolitis, pneumonia: _____
Any heart problems or heart murmurs: _____
Anemia or bleeding problem: _____
Blood transfusion: _____
Frequent abdominal pain: _____
Constipation requiring doctor visits: _____
Bladder or kidney infection: _____
Bed-wetting (after age 5): _____
Any chronic or recurrent skin problems: _____
Frequent headaches: _____
Convulsions or other neurological problems: _____
Diabetes: _____
Thyroid or other endocrine problems: _____
Any other significant problems: _____
Use of alcohol or drugs: _____
[**For GIRLS only**] First menstrual period: _____
[**For GIRLS only**] Any problems with periods: _____

Please list any other information we should know about your child below:

_____

_____

_____

_____

_____

_____

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Medical Records Request

To: Dr._____ _____
(Previous Doctor/Doctor Anterior) (Office Tel/Numero de telefono)

_____ _____
(Address/Direccion) (Office Fax/Numero de Fax)

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

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

Athens Kids Specialists, PC
1500 Oglethorpe Ave, Suite 100 Tel. 706-543-9899
Athens GA, 30606 Fax. 706-613-3995

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

Type of medical records needed:

( ) Complete medical records (including PKU, growth charts, labs and immunization record)

( ) Complete newborn records

( ) Consult notes

Thank you,

_____ _____
(Signature of parent/guardian/Firma del padre/guardian) (Date/Fecha)

_____
(Printed name)

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TB & Lead Questionnaire/TB y Plomo Cuestionario

Name of Patient:
Nombre de Pacient(s):1. _____2. _____3. _____
Person completing form: **Today's date:**
Persona que la contesta: _____ **Fecha de hoy**:_____

Tuberculosis Risk Assessment Evaluación de Riesgos de tuberculosis	Yes/Si	No	Lead Risk Assessment Evaluación de riesgos de plomo	Yes/Si	No
1. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)? Nació su niño en un país de alto riesgo para tuberculosis (países distintos a Estados Unidos, Canadá, Australia, Nueva Zelanda o Europa Occidental)?			1. Does your child have a sibling or playmate who has or had lead poisoning? Tiene el niño un hermano o compañero de juegos que se ha intoxicado con plomo?		
2. Has your child traveled or had contact with someone who has traveled for longer than one week to a country other than canada, Australia, new zealand or western Europe? Ha viajado su nino por mas de una semana a un pais de alto riesgo para tuberculosis (o ha estado en contacto con residentes de esas poblaciones)?			2. Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled? Vive su niño o visita regularmente una casa o guardería construida antes de 1978 que está siendo o ha sido renovada o remodelada recientemente (en los últimos 6 meses)?		
3. Has a family member or contact had tuberculosis or a positive tuberculosis skin test? Ha tenido tuberculosis o un resultado positivo de tuberculina un familiar o un contacto?			3. Does your child live in or regularly visit a house or child care facility built before 1950? Vive su niño o visita regularmente una casa o guardería construida antes de 1950?		
4. Is your child infected with HIV? Esta infectado su nino con el VIH (virus del SIDA)?					

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 ready by a health Professional and the Public Health Department should Be notified.

Las personas que son atendidas por la infección o la Enfermedad tuberculosa ya NO debe hacerse la prueba Del PPD. Cualquier respuesta con un "Si" significa que El niño es de alto riesgo y debe recibir la prueba la Tuberculina o Mantoux.

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.

Al usar el cuestionario, se deben hacer inmediatamente las pruebas de plomo en la sangre, si el niño es de alto riesgo (una o mas) respuestas "Si" o "No se" en el cuestionario de evaluación) para determinar la exposición al plomo.

Dear Parent, the law requires that your child/children have a TB/Lead screen for this well child check.
Estimados padres, es requerido por ley que se llene un cuestionario de tuberculosis y plomo para este chequeo general de su hijo(s).

Reviewed by: Today's date:
Revisado por: _____ (M.D./NP) Fecha de hoy: _____

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Permission to bring a patient

Patient's Name:_____DOB:_____
Patient's Name:_____DOB:_____
Patient's Name:_____DOB:_____
Patient's Name:_____DOB:_____

I, _____ allow the following people to bring my child/children in to any consults that he/she may need if I am not available.

Name: _____Relationship to patient: _____ Tel#:_____
Name: _____Relationship to patient: _____ Tel#:_____
Name: _____Relationship to patient: _____ Tel#:_____
Name: _____Relationship to patient: _____ Tel#:_____

Please be aware that the people listed above will be exposed to the patient's personal information and have to be older than 18 years.

_____ _____
Parent/Guardian Signature Date

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Missed Appointment Policy

Dear Parent,

Our policy on missed appointments is as follows: **"If your child is unable to keep an appointment, please call us 24 to 48 hours prior to your child's appointment to cancel or reschedule. After 3 missed appointments you will be asked to seek medical care elsewhere."**

As a courtesy, our practice calls to remind patients of their appointments. If you do not receive a call from our office it is because your contact information may have changed and the new information was not provided to us. Please call us at 706-543-9899 to reschedule your child's missed appointment and to update your information.

If you call to notify us that your child cannot make his/her appointment, this appointment will be made available to other patients. Thank you for your cooperation.

Acknowledgement of No Show Policy

I hereby acknowledge receiving Athens Kids Specialists, PC's policy on missed appointments. I understand that I must call the clinic 24-48 hours beforehand to cancel/reschedule my child's appointment if my child is unable to keep it. I further understand that the clinic may dismiss my child from the practice for frequent missed appointments.

Name of patient(s):_____

_____ _____
Parent/ Guardian Signature Date

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Notice of Privacy Practices
Aviso de las Practicas de Privacidad

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOUR CHILD (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. KEEP THIS COPY FOR YOUR RECORDS.

Your confidential healthcare information may be disclosed to other healthcare providers for the purpose of providing you with continuum of quality healthcare.
Your confidential healthcare information may be disclosed to insurance providers for the purpose of receiving payment for you with healthcare services.
Your confidential healthcare information may be disclosed to public official or law enforcement agencies in an investigation in which you are the victim of abuse, a crime or domestic violence.
Your confidential healthcare information may be disclosed healthcare professionals in case of healthcare emergency.
Your confidential healthcare information may be disclosed to public health organizations or federal organizations in matters of communicable diseases, defective devices, or a food or medication reaction.
Your confidential healthcare information **CANNOT** be disclosed for purposes other than those which are outlined in this notice.
Your confidential healthcare information may only be disclosed after receiving written authorization from you. You have the right to **REVOKE** your permission to disclose confidential healthcare information **AT ANY TIME**.
You may be contacted by office personnel to remind you of appointments, healthcare treatment options or other health services that may interest you. Messages related to follow up appointments may be left on an answering machine or with an individual answering the phone.
You have the right to restrict the use and disclosure of your confidential healthcare information to family members, friends, or others involved in your healthcare or payments for healthcare services. However, the office may choose to refuse your restrictions if they conflict with providing you with quality healthcare or in the event of a medical emergency.
You have the right to receive confidential communication about your healthcare status.
You have the right to review and request a copy of any and/or all portions of your healthcare information.
You have the right to request changes be made to your healthcare information.
You have the right to know who has obtained your confidential healthcare information and for what reason.
You have the right to have a copy of this Privacy Notice upon request.
The office is required by law to protect the privacy of its patients.
The office will abide by the terms of this notice. We reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
You have the right to complain to the Privacy Officer of this Office and to the Secretary of Health and Human Services if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaints to: **Privacy Officer, Athens Kids Specialists, PC, 1500 Oglethorpe Avenue, Suite 100, Athens GA, 30606.**
All complaints will be investigated. No personal issues will be raised for filling a complaint with the office. For further information about our Privacy Practices, please contact Mr. Sherwin Lopez, Privacy Officer at 706-543-9899.

ESTE AVISO DESCRIBE COMO SU INFORMACION PODRA SER USADA O DADA CONOCER, Y COMO USTED PODRA ACCESAR A ESTA INFORMACION. FAVOR DE REVISAR ESTE AVISO CUIDADOSAMENTE. GUARDE ESTO PARA SUS EXPEDIENTES.

Su información confidencial de cuidado de salud podrá ser dada conocer a otros proveedores de salud con el propósito de proveerle a usted un cuidado de salud con calidad continua.
Su información confidencial de cuidado de salud podrá ser dada conocer a su compañía aseguradora con el propósito de recibir pago por proveerle los servicios de cuidado de salud.
Su información confidencial de cuidado de salud se podrá ser dada a conocer a oficiales públicos o agencias de la fuerza de la ley en una investigación en la cual usted ha sido víctima de abuso, o violencia domestica a criminal.
Su información confidencial de cuidado de salud podrá ser dada a conocer a otros profesionales de cuidado de salud en el caso de una emergencia de su salud.
Su información confidencial de cuidado de salud podrá ser dada a conocer a organizaciones de salud pública u organizaciones federales en el case de una enfermedad contagiosa, un dispositivo medico defectivo, c una reacción negativa a un medicamento o a una comida.
Su información confidencial de cuidado de salud no podrá ser dada a conocer par después de recibir aquellas que están delineadas en este aviso.
Su información confidencial de cuidado de salud podrá ser dada a conocer solamente después de recibir su autorización por escrito. Usted tiene el derecho de revocar su permiso de dar a conocer su información confidencial de cuidado de salud en cualquier momento.
El personal de este despacho podrá recordarle sus citas, opciones u otros servicios de tratamientos que sean de su interés, los mensajes relacionados a citas de seguimiento se pueden dejar en una maquina de recados a con el individuo que contesta el teléfono.
Usted tiene el derecho de restringir el uso y a divulgación de su información confidencial de cuidado de salud a cualquier miembro de su familia, amistades, c otras personas involucradas en el cuidado de su salud a de pago. Sin embargo, el despacho podrá decidir rehusar su restricción par estar en conflicto de proveerle con un cuidado de salud de calidad, o en el evento de una emergencia médica.
Usted tiene el derecho de recibir comunicación confidenciar sobre el estado de su cuidado de salud.
Usted tiene el derecho de revisar requerir una copia de cualquier parte y/o toda a información en su expediente de salud.
Usted tiene el derecho de pedir n cambie de información en su expediente de salud.
Usted tiene el derecho de saber quien ha obtenido su información confidencial de cuidado de salud y saber para qué propósito lo pidieron.
Usted tiene el derecho de obtener una copia de este "Aviso de Privacidad" cuando lo pida.
Este despacho esta requerido por la ley a proteger la privacidad de sus pacientes.
Este despacho actuara de acuerdo a lo previsto en este Aviso de Privacidad. Nosotros tenemos derecho de hacer cambios a este aviso siempre y cuando mantengamos a privacidad de toda información de cuidado de salud.
Usted tiene el derecho de quejarse con el Oficial de Privacidad de este despacho y a la Secretaria de Salud y Derechos Humanos, si usted cree que sus derechos a privacidad han sido previamente violados. Si usted siente que sus derechos de privacidad han sido violados, favor de dirigir sus quejas a ATTN: Privacy Officer, Athens Kids Specialists, PC, 1500 Oglethorpe Avenue, Suite 100 , Athens GA, 30606.
Toda queja será investigada. Este despacho no tomara represalia alguna por as quejas presentadas por usted. Para mas información sobre este "Aviso de Privacidad", favor de contactar al Oficial de Privacidad: 706-543-9899.