



COMPREHENSIVE PEDIATRIC CARE
755 Mt. Vernon Highway, Suite 150
Atlanta, GA 30328
Phone (404)303-1314 Fax (404) 303-1399

RECEIPT OF NOTICES OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT ACKNOWLEDGMENT FORM

I _____ (parent/guardian) acknowledge I have received a copy of the privacy practices and financial policies of Children's Wellness Center LLC

I have read and understand the Privacy Practices and Financial Policy of Children's Wellness Center and agree to the terms and responsibilities as described in the documents. I also authorize Children's Wellness Center to release required medical or other information necessary to process my insurance claims. I also authorize payment of medical benefits directly to Children's Wellness Center.

Child's/ Childrens Name and DOB

Parent/guardian signature _____ Date _____



755 Mt. Vernon Highway, Suite 150
Atlanta, GA 30328
Phone (404)303-1314 Fax (404) 303-1399

PROXY PERMISSION FORM

PATIENTS WHO ARE NOT ACCOMPANIED BY A PARENT OR GUARDIAN

A parent or legal guardian must accompany all children/teens under the age of 18. The parent or guardian can designate another person to seek medical care for their minor by filling this required form.

I, _____, give the following person(s) permission to make medical decisions and to sign any appropriate documents related to my child(ren), _____ in my absence.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I, _____, DO/DO NOT give my child, _____, permission to seek medical treatment by themselves without a parent, caretaker or guardian in accompaniment. I acknowledge that my child is of driving age and has the ability and maturation to understand our medical recommendations.

Signature of Parent: _____ mother/father/legal guardian
Printed Name: _____
Date: _____



PLEASE READ, THIS IS VERY IMPORTANT

Dear Parents,

Please note that every insurance company has different policies regarding coverage for well child checkups, vaccines and ancillary services. Please contact your insurance company to verify your own family's benefits.

Also, please verify that one of the physicians from Children's Wellness Center is listed as your PCP if you have a HMO or POS insurance plan.

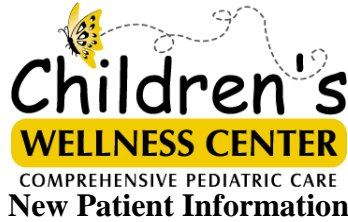
Most important, if we cannot verify that your child has active insurance you will have to pay out of pocket for the visit.

If you have any further questions then please feel free to contact our office manager or your insurance company for more details.

Child/Children's Name and DOB _____

Parent/Guardian Signature _____ Date _____

Relationship to Child _____



Name: _____ Date of Birth: _____
 Referred By: _____

DRUG ALLERGIES: _____

Type of reaction: _____

OTHER ALLERGIES (food or environmental): _____

Current medications: _____

Prior physician: _____

Birth History:

Birth weight _____ Hospital/City: _____

Delivery: ___ On time ___ Premature (how many weeks _____) ___ NICU

___ Breech ___ Vaginal ___ C-Section

Please list any prenatal or postnatal complications: _____

Any Maternal alcohol or tobacco use in pregnancy? ___ Yes ___ No

Developmental History: Please note at what age your child:

- | | |
|-------------------------|--------------------------|
| ___ Lifted head | ___ Smiled |
| ___ Rolled over | ___ Sat up independently |
| ___ Crawled/cruised | ___ Mama/dada |
| ___ First Word | ___ Walked independently |
| ___ Two word sentences | ___ Potty trained |
| ___ Learn to write name | ___ Learn to read |

Medical Problems: please circle those that apply

- | | |
|---|--|
| <input type="checkbox"/> Asthma/wheezing/bronchiolitis | <input type="checkbox"/> Eczema or other skin problem |
| <input type="checkbox"/> Gastroesophageal reflux (GERD) | <input type="checkbox"/> Weight loss/weight gain |
| <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Recurrent colds | <input type="checkbox"/> Vision Problems/Glasses |
| <input type="checkbox"/> Anemia (Low iron/blood count) | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Accidental day |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> or night time wetting |
| <input type="checkbox"/> Constipation or diarrhea | <input type="checkbox"/> Recurrent Throat Infections |
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Speech/Hearing problems | <input type="checkbox"/> Autism or other developmental disorders |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Any other medical problems: |
| <input type="checkbox"/> Recurrent stomachaches | Please describe _____ |

Medical History:

Hospitalizations/Location/Year/Reason: _____

Surgical History:

Please list any surgeries or broken bones/Year: _____

Social History:

Who lives in home with child? _____

____ Daycare ____ Home school ____ Private/public school

Does anyone in the home smoke, abuse alcohol or drugs? _____

Do you suspect that your child smokes, uses alcohol or drugs? _____

Extra curricular activities: _____

How many hours per day does your child spend on computer or tv? _____

How much exercise or vigorous activity does your child have per day? _____

Do you have any concerns regarding your child's eating habits/weight or height? _____

Do you have any concerns regarding your child's appearance or attitude? _____

Do you have any concerns regarding your child's grades or academic appearance? _____

Do you speak more than one language at home? If yes what other languages _____

Family History: Please list age and health of immediate family members:

Mother: _____

Father: _____

Siblings: _____

Are any of your children or immediate family members deceased? _____

Please check and list who is affected by the following conditions:

- Asthma
- Alcoholism/Drug addiction
- Allergies
- Blood disorders including anemia
- Birth defects
- Behavioral disorders including autism,ADHD
- Cancer
- Diabetes (Type I or II)
- Genetic defects
- Heart/cardiovascular disease
- Other _____
- High blood pressure
- Immune deficiency (including HIV/AIDS)
- Kidney disease
- Mental/psychiatric disorder
- Autoimmune disease
- Seizures
- Sudden death
- Thyroid disease
- Eye abnormalities including cataracts, vision problems, blindness

Parent/guardian signature: _____

Date: _____

Physician reviewed/signature: _____

Date: _____