Children's
WELLNESS CENTER
COMPREHENSIVE PEDIATRIC CARE

Date: **Child's Primary Doctor:**

Patient Name:_____
Last First Middle Nickname

Address:_____
Street Address

_____
City State Zip Code County

Primary Number: (____)_____ Secondary Number: (____)_____
Date of Birth:_____ Age:_____ Gender:_____
Social Security #:_____

How did you hear about us: _____
Please List all siblings with ages_____
_____

RESPONSIBLE PARTY INFORMATION

Whoever brings in the child is responsible for any fees at the time of service.

Parent/Guardian 1:
Name:_____
Relation to Child: _____
Home Phone:_____
Employer:_____
Work Phone:_____
Cell Phone:_____
Email:_____
Soc. Sec. No.:_____
DOB:_____

Parent/Guardian 2:
Name:_____
Relation to Child: _____
Home Phone:_____
Employer:_____
Work Phone:_____
Cell Phone:_____
Email:_____
Soc. Sec. No.:_____
DOB:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:
Insurance Company :_____
ID Number:_____ Group Number:_____
Cardholder's Name:_____ DOB:_____
SECONDARY INSURANCE:
Insurance Company Name: _____
ID Number:_____ Group Number:_____
Cardholder's Name:_____ DOB:_____

EMERGENCY CONTACTS (other than parents)

Name: _____ Relation to Patient:_____
Phone #_____

CONSENT FOR MEDICAL CARE AND ASSIGNMENT OF BENEFITS

I authorize Children's Wellness Center to provide medical care for my child/children. I authorize payment of medical benefits directly to Children's Wellness Center for services provided. I authorize physician to release any medical information required to process my claims.

Signature:_____ Date: _____

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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_____

Rev 03/10

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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: _____

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PLEASE READ, THIS IS VERY IMPORTANT

Dear Parents,

Please be sure to contact your insurance company to add your newborn to your insurance policy. Insurance companies usually only cover newborns for the first 30 days. It is the parent's responsibility to add a child within that time frame. Our practice suggests that you add the baby within the first two weeks so there is no gap in coverage. If the baby is not added within the required time frame then **you will be financially responsible** for **all** medical charges incurred since birth.

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_____

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Past Medical History

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
_____Rolled over
_____Crawled/cruised
_____First Word
_____Two word sentences
_____Learn to write name
____Smiled
____Sat up independently
____Mama/dada
____Walked independently
____Potty trained
____Learn to read

Medical Problems: please circle those that apply

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

Parent/guardian signature: _____ Date: _____

Physician reviewed/signature: _____ Date: _____