Children's Medicine of Rockdale

1765 Parker Road, Suite B210, Conyers, GA 30094
Phone: 770.761.0672 Fax: 770.761.0784 Web: www.rockdalekids.com

New Patient Information

Patient's Full Name ____________________ Nickname ____________________

Street Address ____________________ Gender ____________________

City ____________ State ____________ ZIP ____________ Date of Birth ____________________

Emergency Contact – Name ____________________ Emergency Contact – Phone ____________________

Preferred E-mail address ____________________

Parent/Legal Guardian Information

Mother's full name ____________________ Social Security Number ____________________

Street Address (if different from above) ____________________ Date of Birth ____________________

Home Telephone ____________________ Cell Phone ____________________

Marital status (indicate Single/Married/Divorced/Separated/Widowed) ____________________

Father's full name ____________________ Social Security Number ____________________

Street Address (if different from above) ____________________ Date of Birth ____________________

Home Telephone ____________________ Cell Phone ____________________

Marital status (indicate Single/Married/Divorced/Separated/Widowed) ____________________

Allergies/Referrals/Reason for Visit

Primary reason for today's visit ____________________

Known allergies to medication (if any, otherwise, write None) ____________________ Referred by ____________________

Mother's OB/GYN if patient is a new born ____________________ Pharmacy Telephone ____________________

Preferred primary physician (if no preference, please write **First Available**) ____________________

Birth History

Patient Name____________________ Patient Date of Birth_____________

Place of Birth (hospital name) _____________________________________

Type of Delivery (vaginal, c-section,forceps,breech, vacuum)_____________

Any Birth Complications ?____

Any Newborn Complication? ______________________________________

Child's birth weight ____________

Hearing Screen passed? _____________

Was Hepatitis B given at hospital? ___________________

Was Mothers pregnancy healthy? ____________________________________

Is child adopted? ____________ Is child aware? ______________

Surgery/Hospitalization History

Any non-surgical overnight hospitalizations? _________________________

____

Any surgical procedures (includes PE tubes) (type and year)______________

____

Health Issues (yes or no)

Allergies (medications,food or seasonal)______________________________

____

Asthma___________
Eczema __________
Recurring Ear Infections ____________
Urinary Tract Infections ______________
Seizures ____________
Strep Pharyngitis ________________
ADHD ____________ Year Diagnosed__________
Psychological Health ________________
Vision Problems __________________Contacts or Glasses _______
Hearing Problems _________________Hearing Aid __________

Other____

____

____

____

Medications

Please list any current (or seasonal) medications your child may use. Name, dose and schedule.

____

____

Childhood Illnesses

History of Chicken Pox or Shingles ___________________ year______

History of Measles, Mumps or Rubella ________________ year_______

History of Meningitis ___________________year ______

Family Medical History (please list affected family member)

Allergies (medication, seasonal) _________________________________

Anemia / Blood disorders _______________________________________

Asthma____

Cancer____

Diabetes ____

High Cholesterol ____

Hypertension ____

Sickle Cell Disease ____

Other ____

Child's Social History

Are parents married, divorced, separated or partners___________________

Primary Caretaker ____________________

Who Lives at Child's primary residence ______________________________

Does anyone smoke at Child's primary residence ______________________

School Name and Grade ____

Daycare __________________________ How many days a week ________

School Performance (please circle all that apply)
Excellent Good Fair Poor Behavior or Attention problems

Adolescent Female History

Onset of menses (age or year)________________________________
Any problems with menstrual cycle ? ____________________________
Is Menstrual cycle regular ? ___________________________________
Has patient ever been pregnant ? _______________________________
Is patient sexually active ? ____________________________________

Prior Screening Tests

ADHD Testing ? Yes No If yes, what year ___________

School Age Hearing Screening?___________ What year?__________
School Age Vision Screening?___________ What year?___________

Other Test
History____
____

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Patient Express Registration Form
General Patient/Guardian/Insurance Information

Insurance Information

Primary Insurance Company ______________________ Contract Number ______________________

Insured Name ______________________ Policy Number ______________________

Street Address ______________________ Telephone Number ______________________

Secondary Insurance Company ______________________ Contract Number ______________________

Insured Name ______________________ Policy Number ______________________

Street Address ______________________ Telephone Number ______________________

IMPORTANT: Please give a copy of your insurance card to the receptionist

Additional Notes

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I hereby authorize Children's Medicine of Rockdale to file my insurance and release medical information as necessary to my insurance company. I understand that I will be responsible for any unpaid balance.

Payment is expected at the time of service

Signature of Responsible Party ______________________ Date ______________________

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, the undersigned, have had the opportunity to review a copy of Children's Medicine of Rockdale Notice of Privacy Practices

____ ________________
Signature of Parent/Legal Guardian Date

____
Name of Parent/Legal Guardian (Please Print)

____
Name of Patient (Please Print)