Peds & Parents Family Care, LLC

Boards Certified Physician & Nurse Practitioners
124-B Andrews Way
Saint Marys, Georgia 31558
912-729-7007

Patient Application & Registration

We ask that you take the time to complete the "Patient Application & Registration" questionnaire in full. Our providers rely on your thorough and honest answers to determine if they will be able to provide beneficial care to you.

Patient Information

First Name	Middle Name	Last Name
Date of Birth (mm/dd/yyyy)	Social Security Number	Gender
		☐ Male ☐ Female

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Disclose

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Preferred Language ☐ English ☐ Spanish ☐ Other:

Email:

Mailing Address	City	State	Zip

Primary Phone	Secondary Phone	Alternate Phone
Emergency Contact Name	Relationship to Patient	Emergency Contact's Phone

Employment Information

Employer	Occupation	Employer Phone

Guarantor Information (Responsible Party – If other than the patient)

Guarantor Name:

Patient's Relationship to Guarantor: ☐ Dependent ☐ Spouse ☐ Other

Guarantor Date of Birth (mm/dd/yyyy)	Guarantor Social Security Number

Guarantor Address	City	State	Zip

Guarantor Primary Phone:

Guarantor Email Address:

OFFICE USE ONLY BELOW THIS LINE

I have reviewed the registration information and medical history submitted for this prospecitve patient. This patient has (☐ BEEN APPROVED / ☐ NOT BEEN APPROVED) to receive care from Peds & Parents Family Care, LLC.

_____ _____

Provider's Signature *Date*

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Insurance Information

Primary Insurance	Claims Address	
Insurance Phone Number	Policy #/Member ID	Group Number
Patient's relationship to policy holder	☐ Self ☐ Spouse ☐ Dependent ☐ Other	
Policyholder's Name	Policyholder Date of Birth	Policyholder Social Sec #

Secondary Insurance	Claims Address	
Insurance Phone Number	Policy #/Member ID	Group Number
Patient's relationship to policy holder	☐ Self ☐ Spouse ☐ Dependent ☐ Other	
Policyholder's Name	Policyholder Date of Birth	Policyholder Social Sec #

Preferred Pharmacy – Please complete as we use E-Prescribe

Preferred Pharmacy Name	Preferred Pharmacy Phone Number		
Pharmacy Address	City	State	Zip

Additional Questions

Are you a former Peds & Parents Patient? ☐ Yes ☐ No

If so, approximately how long ago do you believe you were last seen:_____

How did you hear about Peds & Parents? If you were referred to us, please indicate who referred you. _____

Reason for requested appointment: _____

Immunizations

☐ Up to date ☐ Not immunized ☐ Not up to date ☐ Not sure

State of Vaccination(s): ☐ Georgia ☐ Other

Medical office(s) that administered vaccines:

Name of office	Telephone	City	State

Certification of Completion

I have supplied the above information on behalf of myself or my dependent and attest that it is true and complete to the best of my knowledge.

_____ _____

Signature Date

Relationship to Patient_____

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FOR MINOR PATIENTS ONLY

Parent or Guardian Information			
First Name	Middle Name	Last Name	
Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship to Patient	
Email Address:			
Mailing Address	City	State	Zip
Primary Phone	Secondary Phone	Additional Phone	

Frist Name	Middle Name	Last Name	
Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship to Patient	
Email Address:			
Mailing Address	City	State	Zip
Primary Phone	Secondary Phone	Additional Phone	
Marital Status of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married			

Adults permitted to bring child for care OR receive medical information about the child:	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Home and Social History	
Who lives in the house with your child?	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

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FOR ALL PATIENTS

Social History					
		Former	Current	N/A	Amount/Frequency
☐	Tobacco	☐	☐	☐	
☐	Alcohol	☐	☐	☐	
☐	Drugs	☐	☐	☐	

Parents and Siblings				
Mother	☐ Living	☐ Deceased	Age at death:	
Father	☐ Living	☐ Deceased	Age at death:	
Brother(s)	How many?		Living?	Deceased?
Sister(s)	How many?		Living?	Deceased?

Family History		
Please include parents, grandparents, and siblings		
		Family Member(s)
☐	Coronary Artery Disease	
☐	Hypertension	
☐	Hyperlipidemia	
☐	Stroke	
☐	Diabetes	
☐	Kidney Disease	
☐	Breast Cancer	
☐	Colon Cancer	
☐	Prostate Cancer	
☐	Mental Illness	
☐	Substance/Alcohol Abuse	
☐	Other:	
☐	Other:	
☐	Other:	
☐	Other:	

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Major Medical History: (High Blood Pressure, Diabetes, Asthma, ADHD, etc)

_____

_____

_____

_____

_____

_____

_____

Surgeries:

_____

_____

_____

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_____

_____

_____

List ALL Medications:

_____

_____

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_____

Other Specialists Seen:

_____

_____

_____

_____

_____

_____

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VACCINE POLICY AGREEMENT

Immunizations – Vaccinating children and adult patients may be the most important health promoting intervention that is performed by health care providers. Because vaccines are effective at preventing serious illnesses and saving lives, it is our policy to vaccinate and immunize all children and adult patients that are cared for at this facility. Due to the serious health hazards of not vaccinating children and adult patients, if you (parent/guardian/adult) at any time choose to NOT VACCINATE yourself or your child, we will request that you SEEK CARE FROM ANOTHER CLINIC.

ACKNOWLEDGMENT

I have read and understood Peds and Parents Family Care's policy regarding vaccines for children and adult patients and agree to comply. If at anytime I refuse to have myself, or my child, vaccinated for required vaccines, I understand this will result in dismissal of care from the practice.

_____ _____
Parent/Guardian/Patient PRINTED name Date

_____ _____
Parent/Guardian/Patient SIGNATURE Date

_____
Patient Name

HIPAA POLICY

Please read our HIPAA policy via our website for information on how personal health information (PHI) is used at Peds and Parents Family Care, LLC. All new and established patients have signed a HIPAA agreement form and have acknowledged they read our HIPAA Policy. If you prefer, a print or electronic copy in PDF format will be provided to you for your review.

ACKNOWLEDGMENT

I acknowledge that I have read and fully understand the HIPAA consent form located on our website. I have also read risks and benefits of patient portal use and agree that I understand the risks associated with online communications between physician and patient, and consent to the conditions outlined within. I acknowledge that using the patient portal is voluntary and will not impact the quality of care I receive from Peds and Parents Family Care, LLC should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. The patient portal is the most secure way to communicate with the patient. It is required by law that we provide access to your/your dependents medical record and allow you to correct discrepancies in the medical record.

_____ _____
Parent/Guardian/Patient PRINTED name Date

_____ _____
Parent/Guardian/Patient SIGNATURE Date

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Authorization for Release of Medical Information from Previous Healthcare Provider/Specialist

I hereby request and authorize the following healthcare providers:

_____ Previous Healthcare Provider's Name

_____ Office Name

_____ Office Location

_____ Office Phone

_____ Office Fax

_____ Type of Specialty (if applicable)

To release the following type(s) of information:

_____ Shot Records

_____ Complete Medical Record

_____ Consult Notes

For: Name (PRINT): _____ DOB: _____

For the purpose of continuity of care, please release these records to:

Peds & Parents Family Care LLC
124 Andrews Way, Suite B
St. Marys, GA 31558
Phone: 912-729-7007
Fax: 912-729-3627

All information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until I withdraw this consent by providing written notification to Peds & Parents Family Care LLC at the above address.

_____ _____
Signature of patient, or patient's legal guardian Date:

_____ _____
Printed name of patient, or patient's legal guardian Date:

_____ _____
Signature of Witness Date: