Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

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

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Initial History Questionnaire

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

HE0328

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GA Kidz Pediatrics

Patient Registration Form

PATIENT INFORMATION:

Last Name _____ First name_____ Middle Name_____

Goes By:_____ RACE: (please circle) White Black Hispanic Other

Language: (please circle) English Spanish Other Ethnicity (Please Circle) Hispanic/Latino Non Hispanic/Non Latino Refuse to Report

******PATIENT PHONE NUMBER :*** _____ ********

Social Security #_____ Sex: Female ( ) Male ( )

Date of Birth:_____ **EMAIL:** _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Emergency Contact:_____ Emerg Phone #_____

Siblings: _____

Allergies to Medications _____

PARENT INFORMATION: (List person or Insured Name responsible for payment-use full legal names no nicknames PLEASE)

Person responsible for Payment: Mother ( ) Father ( )

Other person who can give consent if parents cannot be reached, please provide name and relationship: _____

Mother's First & Last Name: _____ DOB:_____ SS#_____

Mother's maiden name:_____ Mother's work # _____

Mother's Employer: _____ Mother's cell # _____

Father's First & Last Name: _____ DOB:_____ SS#_____

Father's Employer: _____ Father's cell # _____ Father's wk: _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

Primary Insurance Company: _____

Policy Holders name: _____ Policy Holders DOB: _____

Policy Holders SS# _____ Policy Holders Employer; _____

POLICY ID# _____ GROUP # _____

Secondary Insurance Company: _____

Policy Holders name: _____ Policy Holders DOB: _____

Policy Holders SS# _____ Policy Holders Employer; _____

POLICY ID# _____ GROUP # _____

******Parent / Guardian Signature:*** _____ ***DATE:*** _____ ********

GA KIDZ PEDIATRICS, PC

AUTHORIZATION FOR TREATMENT OF A MINOR

I / we hereby give permission for medical treatment to be rendered to the following minor:

PATIENT NAME: _____ DOB: _____

I / we authorize necessary treatment from Physicians and / or staff at:

Facility Name and address: **GA KIDZ PEDIATRICS**

146 Sylvan Dr

Jackson, GA 30233

Dr Lezlie F.Biles M.D.

Treatment may be authorized by the following presenting person/s named below. This authorization will remain in effect until written notice of cancellation.

*Name: _____ Relationship: _____

Address: _____ Phone # _____

*Name: _____ Relationship: _____

Address: _____ Phone # _____

*Name: _____ Relationship: _____

Address: _____ Phone # _____

****

I / we understand and agree that I / we are responsible for any payment of any and all charges for services rendered to said minor.

NOTE: PLEASE explain any special parental, custodial or guardianship relationships, include name, address, phone # and relationship below.

_____

Authorization given by Name: _____

Date: _____ Relationship: _____

GA KIDZ PEDIATRICS

DISCLOSURES & CONSENTS

PATIENT FULL NAME: _____ **DOB:** _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to GA KIDZ PEDIATRICS or the physician individually for services rendered to my dependants or me by the physician or under his / her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pays or balance due that GA KIDZ PEDIATRICS is unable to collect from my insurance carrier for whatever reason.

ALL CO-PAYS ARE DUE AT TIME OF SERVICE

Failure to do so will result in a billing fee on your account. You are ultimately responsible for your account. Payment is expected within 45 days, either from you or your insurance company. You should contact you insurance company regarding any balances over 30 days.

MEDICAL RECORD RELEASE

I authorize the release of medical information via phone, fax, or mail to the primary physician and other physicians/facilities involved in the care of this patient. I authorize the release of immunization records / forms via fax, mail, or pick up to the patient/guardian, schools, daycares and other institutions that require them. I authorize the release of pertinent medical / billing information to the insurance company for the purpose of processing claims for services rendered.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the GA KIDZ PEDIATRICS patient information Privacu Policy. I hereby authorize GA KIDZ PEDIATRICS ot the physician individually to release any of my or my dependents medical or incidental nonpublic personal information that maybe necessary for medical evaluation, treatment, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR EMAIL:

I certify that I understand the privacy risk of the mail, phone calls, and email. I hereby authorize a GA KIDZ PEDIATRICS representative or my physician to mail, call, voice mail or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to resign this authorization at any time by notifying GA KIDZ PEDIATRICS that effect in writing.

LAB/XRAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, xray, or other diagnostic services. I further understand that I am financially responsible for any copay or balance due for the services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my GA KIDZ PEDIATRICS physician or his / her designee.

PARENT / GUARDIAN SIGNATURE: _____

Lezlie F. Biles, M.D.

GA Kidz Pediatrics, P.C.

146 Sylvan Drive • Jackson, Georgia 30233 • 770-775-4540

PATIENT ACKNOWLEDGEMENT RECEIPT OF PRIVACY NOTICE

I,_____(Patient's name) hereby affirm that I have received a copy of the Notice Of Privacy Practices from **GA KIDZ Pediatrics, PC.** Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the Notice, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the Notice Of Privacy Practices from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name:_____

_____

Signature of Patient or Personal Representative/Parent

_____

Name of Patient or Personal Representative/Parent

Date:_____

FOR OFFICE USE ONLY

Received by:	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	

GA KIDZ PEDIATRICS, PC

MEDICAL RECORDS RELEASE

By signing this form, I authorize, Previous Physician Name:_____

Address:_____Phone #:_____

to release or disclose the protected health information described below to:

GA KIDZ PEDIATRICS, PC,

146 Sylvan Dr.

Jackson, GA 30233

Phone: 770-775-4540

Fax: 770-775-4078

This authorization will expire upon fulfillment of request, unless otherwise specified.

I authorize copies of ALL medical records be released to GA KIDZ Pediatrics. I understand that information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV, or pregnant related issues. It may include information about behavior or mental health services and treatment for alcohol or drug abuse.

_____ OTHER (PLEASE SPECIFY)_____

PATIENT NAME:_____DOB:_____

SIGNATURE:_____DATE:_____

RELATIONSHIP TO PATIENT:_____

_____(INITIALED BY PATIENT/GUARDIAN) RELEASED RECORDS TO PATIENT DIRECTLY

Patient or their representative may revoke this authorization by notifying in writing GA KIDZ Pediatrics designated Privacy Officer. Federal law states that treatment, payment enrollment, eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the privacy rule. Federal law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient. By signing, patient or their representative understands the matters discussed on this form and releases the provider, and all persons associated with this company from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. Patient/representative understands he/she does not have to sign this authorization in order to obtain healthcare treatment.