

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**MEDICAL HISTORY  
(Ages Birth to 5 Years)**

**FAMILY HISTORY**

Mother: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Health: \_\_\_\_\_

Father: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Health: \_\_\_\_\_

Siblings (Name/Date of birth/Health): \_\_\_\_\_

Family Health Problems (Check appropriate items):

- |   |                                       |                                       |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heart attack or stroke at age less than 60 | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Cholesterol                           | <input type="checkbox"/> Sudden Death | <input type="checkbox"/> Allergies    |
| <input type="checkbox"/> High Blood Pressure                        | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Cancer       |
|   | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Other _____  |

**CHILD'S HEALTH HISTORY**

Birth: Weight \_\_\_\_\_ Type of delivery \_\_\_\_\_

Apgars \_\_\_\_\_

Problems during pregnancy: \_\_\_\_\_

Newborn problems: \_\_\_\_\_

Hospitalizations/Surgery: \_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_ Allergies to medication: \_\_\_\_\_

Current medications: \_\_\_\_\_

Check appropriate items child has had in part:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Urinary Infection        |
| <input type="checkbox"/> Bronchiolitis/Bronchitis | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Frequent Abdominal Pains |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Frequent Sore Throats   | <input type="checkbox"/> Allergies                |
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Seizures                | <input type="checkbox"/> Chicken Pox              |
| <input type="checkbox"/> Fainting Spells          | <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Other _____              |

Has your child had any problems in his/her development? \_\_\_\_\_

Former Pediatrician and other Specialists who has seen your child (name/location): \_\_\_\_\_

**NORTH FULTON PEDIATRICS - FORM PACKET FOR AGES BIRTH TO 5 YEARS**

**PATIENT INFORMATION**

PATIENT \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

\_\_\_\_\_

S.S. # \_\_\_\_\_

\_\_\_\_\_

PHONE # \_\_\_\_\_

**PARENT INFORMATION**

FATHER'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

S.S. # \_\_\_\_\_

S.S. # \_\_\_\_\_

ADDRESS (CHECK IF SAME AS PATIENT \_\_\_\_)

ADDRESS (CHECK IF SAME AS PATIENT \_\_\_\_)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOME PHONE # \_\_\_\_\_

HOME PHONE # \_\_\_\_\_

WORK PHONE # \_\_\_\_\_

WORK PHONE # \_\_\_\_\_

CELL PHONE # \_\_\_\_\_

CELL PHONE # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

I.D. # (S.S. #) \_\_\_\_\_

CLAIM ADDRESS \_\_\_\_\_

GROUP # \_\_\_\_\_

\_\_\_\_\_

I authorize the release of any medical or other information necessary to process my child's insurance claim. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to North Fulton Pediatrics, P.C. for services rendered and agree to the below stated method of payment and terms of payment.

SIGNATURE OF INSURED \_\_\_\_\_ DATE \_\_\_\_\_

**NEAREST RELATIVE OR PERSON TO CONTACT IN CASE OF AN EMERGENCY:**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

**HOW DID YOU HEAR OF NORTH FULTON PEDIATRICS?**

FRIEND \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

YELLOW PAGES \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_ OTHER \_\_\_\_\_

**METHOD OF PAYMENT:** CASH \_\_\_\_\_ CHECK \_\_\_\_\_ OTHER \_\_\_\_\_ MEDICAID \_\_\_\_\_

**WE RESERVE THE RIGHT TO CHARGE INTEREST IN THE AMOUNT OF 1.5% MONTHLY (18% ANNUALLY) AS PROVIDED BY THE STATE LAW ON ALL ACCOUNTS UNPAID 60 DAYS AFTER SERVICE IS PROVIDED.**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

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**(Ages Birth to 5 Years)**

**FAMILY HISTORY**

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Health: \_\_\_\_\_

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## **NORTH FULTON PEDIATRICS, P. C. FINANCIAL POLICY**

Thank you for choosing North Fulton Pediatrics as your health care provider. Please understand that payment of your bill is considered a part of your care. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your visit.

All co-payments and deductibles are due at the time of service. These fees cannot be waived. For your convenience, we accept cash, check, Visa/MasterCard (including debit cards), American Express and Discover.

### **NON-CONTRACTUAL INSURANCE**

For those plans with which we do not have a relationship, you will be responsible for your entire bill at the time of service. We will provide you with a copy of your bill, at each visit, so you will be able to file your claim with your insurance company.

### **CONTRACTUAL INSURANCE**

If we are a participating provider, all co-pays and co-insurance amounts are due at the time of service. In the event that your insurance coverage changes to a plan for which we are not a participating provider, we will provide you with a bill so you will be able to file the claim with your insurance company. The full amount will then be due at the time of service.

Please be aware that some of the services provided may be non-covered services and not considered reimbursable under your insurance plan. You are personally responsible for these services.

We will routinely file your insurance claim for each visit. Should there be a dispute with your insurance company we will attempt to resolve it with you. During this time a statement will be mailed to you each month your account shows a balance due. For all insurance other than HMO's, if your insurance has not paid within 90 days; the balance may be transferred to your personal balance, which must be paid upon receipt. Your insurance policy is a contract between you and your insurance company; therefore, your balance is your responsibility.

### **VACCINES FOR CHILDREN (VFC) PROGRAM**

Children who are not insured, or are insured but do not have vaccine coverage, are enrolled in Medicaid, or are American Indian or Native Alaskan qualify for the Vaccines For Children program. The vaccines are provided free of charge, but there is an administration fee, which is your responsibility. If your child qualifies and you would like to participate in the VFC program, it is required that the nurse be told at the beginning of your child's visit. We cannot implement this program retroactively.

### **INTEREST**

We reserve the right to charge interest in the amount of 1.5% monthly (18% annually) as provided by the state law on all past due account balances.

### **ADMINISTRATIVE FEE**

Participation forms for camp, school, and sports, etc. will be charged a \$10.00 processing fee payable in advance. Any 2<sup>nd</sup> request for state forms will be charged a \$10.00 fee payable in advance.



# North Fulton Pediatrics

## Receipt of Notice of Privacy Practices Written Acknowledgement Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, have had the opportunity to review a copy of North Fulton Pediatrics Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

**FOR INTERNAL USE ONLY**

Patient/Parent/Guardian refused to sign \_\_\_\_\_  
Date

\_\_\_\_\_  
Initials

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I hereby grant permission to North Fulton Pediatrics to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up, or to conduct any other relevant business that is deemed necessary.

*Personal or detailed information will not be left on an answering machine or voice mail.*

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

**FOR INTERNAL USE ONLY**

Patient/Parent/Guardian refused to sign \_\_\_\_\_  
Date

\_\_\_\_\_  
Initials