PAL
Pediatric Associates of Lawrenceville

Patient Registration Form

Last Name: _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Primary Phone: (_____) _____ - _____

Who lives in the household? _____

Referred By: Hospital/OB_____ PAL Website ____ Ins. Co._____ Other (name) _____

Already Est: _____

Primary Contact: *Name*: _____ *Relation to Patient*: _____

For Family Medical History Reasons: Is this contact genetically related to the Child? Yes / No

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Phone: (____) _____ - _____ *Email*: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email

Secondary Contact: *Name*: _____ *Relation to Patient*: _____

For Family Medical History Reasons: Is this contact genetically related to the Child? Yes / NO

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Phone: (____) _____ - _____ *Email*: _____ _____

If this contact will need to be notified in addition to the primary contact for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here: _____

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Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____

ID# _____ *Group #* _____

Additional Contact Questions:

Who should receive billing statements? _____
Name Relationship

PLEASE PROVIDE ADDRESS ***IF DIFFERENT FROM ONE ABOVE****:*

_____

(Street or PO Box) *(City)* *(State & Zip)*

May all contacts have access to the patient's records? Yes / No / _____

If parents are divorced or separated please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Emergency Contacts, other than parents: Name & Relationship

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PEDIATRIC ASSOCIATES OF LAWRENCEVILLE, LLC AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I VOLUNTARILY CONSENT TO EXAMINATION AND TREATMENT OF MYSELF/OR MY DEPENDENTS. I WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGES EXCEPT THOSE UNDER THE CONTRACTUAL ARRANGEMENTS WITH CERTAIN INSURERS OF PEDIATRIC ASSOCIATES OF LAWRENCEVILLE, LLC.

I GIVE PERMISSION FOR THE FOLLOWING PERSON(S) TO ACCOMPANY MY CHILD FOR MEDICAL TREATMENT AND TO MAKE MEDICAL DECISIONS IN MY ABSENCE:

1: _____ *Phone*: (_____) _____ - _____
(Name) (Relationship)

2: _____ *Phone*: (_____) _____ - _____
(Name) (Relationship)

Signature of Patient, Parent or Guardian:_____ **Date**:_____

Relationship to Patient: _____

Patient Registration Form

PEDIATRIC ASSOCIATES OF LAWRENCEVILLE, LLC

Child's Name:_____

Household:

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

Name	Relationship to child	Birth date	Health problems

What is the child's living situation?
____ Lives with mother and father ____Lives with adoptive parents ____ Joint custody ____ Single custody ____ 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:

- ☐ **Birth History unknown**

Vaginal ____ C-Section ____ Full Term ____ Premature____ (if yes, weeks completed ____)

Birth Weight: Length:

Were there any prenatal or neonatal complications? Yes____ No____

Was a NICU stay required? Yes____ No____ if yes please explain_____
_____

General History:

Do you consider your child to be in good health? Yes____ No____
If no, please explain _____
_____

Do you think your child's development is: On Target____ Delayed____
If delayed, please explain: _____
_____

Has your child ever been hospitalized or had surgery: Yes____ No____
If yes, please explain: _____
_____

Is you child allergic to medications or foods Yes____ No____
If yes, please explain: _____
_____

Form Completed By:_____

Signature:_____ **Date:**_____

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Child's Name: _____ Past Medical History:

Does your child have, or has your child ever had,				
Chicken Pox	Yes	No	Unknown	When_____
Frequent ear infections	Yes	No	Unknown	Explain_____
Problems with ears or hearing	Yes	No	Unknown	Explain_____
Nasal allergies	Yes	No	Unknown	Explain_____
Problems with eyes or vision	Yes	No	Unknown	Explain_____
Asthma, Bronchitis, bronchiolitis or pneumonia	Yes	No	Unknown	Explain_____
Any heart problems or heart murmur	Yes	No	Unknown	Explain_____
Anemia or bleeding problems	Yes	No	Unknown	Explain_____
Blood transfusion	Yes	No	Unknown	Explain_____
HIV	Yes	No	Unknown	Explain_____
Organ transplant	Yes	No	Unknown	Explain_____
Cancer	Yes	No	Unknown	Explain_____
Genetic disorder	Yes	No	Unknown	Explain_____
Frequent abdominal pain	Yes	No	Unknown	Explain_____
Constipation requiring doctor visit	Yes	No	Unknown	Explain_____
Recurrent urinary tract infection/problems	Yes	No	Unknown	Explain_____
Kidney disease or urological malformation	Yes	No	Unknown	Explain_____
Bed-wetting (after 5 years)	Yes	No	Unknown	Explain_____
Sleeping problems, snoring	Yes	No	Unknown	Explain_____
Recurring skin problems (acne, eczema)	Yes	No	Unknown	Explain_____
Epilepsy or convulsions	Yes	No	Unknown	Explain_____
Obesity	Yes	No	Unknown	Explain_____
Diabetes	Yes	No	Unknown	Explain_____
Thyroid or endocrine problems	Yes	No	Unknown	Explain_____
High Blood pressure	Yes	No	Unknown	Explain_____
High cholesterol	Yes	No	Unknown	Explain_____
Serious injuries, fractures or concussions	Yes	No	Unknown	Explain_____
Alcohol or drug use	Yes	No	Unknown	Explain_____
ADHD, anxiety, mood problems or depression	Yes	No	Unknown	Explain_____
Dental decay	Yes	No	Unknown	Explain_____
Sexually transmitted infections	Yes	No	Unknown	Explain_____
(For girls) had first period	Yes	No	Unknown	When_____

Family history

☐ **Family history Unknown**

Have the child's parents, *grandparents or siblings* have/had any of the following?

Childhood hearing loss	Yes	No	Unknown	Explain_____
Nasal allergies	Yes	No	Unknown	Explain_____
Asthma	Yes	No	Unknown	Explain_____
Tuberculosis	Yes	No	Unknown	Explain_____
Heart disease (before 55 yrs.)	Yes	No	Unknown	Explain_____
High Cholesterol	Yes	No	Unknown	Explain_____
Anemia	Yes	No	Unknown	Explain_____
Bleeding disorder	Yes	No	Unknown	Explain_____
Dental decay	Yes	No	Unknown	Explain_____
Cancer (before 55 yrs.)	Yes	No	Unknown	Explain_____
Liver disease	Yes	No	Unknown	Explain_____
Kidney disease	Yes	No	Unknown	Explain_____
Diabetes	Yes	No	Unknown	Explain_____
Bed-wetting (after 5yrs)	Yes	No	Unknown	Explain_____
Obesity	Yes	No	Unknown	Explain_____
Epilepsy or convulsions	Yes	No	Unknown	Explain_____
Alcohol abuse	Yes	No	Unknown	Explain_____
Drug abuse	Yes	No	Unknown	Explain_____
Mental illness/Depression/anxiety	Yes	No	Unknown	Explain_____
Immune problems	Yes	No	Unknown	Explain_____
HIV/AIDS	Yes	No	Unknown	Explain_____
Tobacco Use	Yes	No	Unknown	Explain_____

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Patient Registration Form
Office Policies and Procedures

Child's name_____

Please Initial

_____ **PHONE SYSTEM**: We strive to answer our calls live, however, during times of heavy call volume, the phone system will be answered by our automated system. Please listen carefully to the menu so that your call is directed to the appropriate department with little or no waiting time. Leaving multiple messages on multiple lines will delay your call back.

_____ **CELL PHONES**: To set a good example for your children and to have a productive visit, please turn off your phone and Electronic devices when any staff member is in the room.

_____ **WALK-INS**: If you walk in without an appointment, you may be directed to the Urgent Care Facility or the Emergency Room**. We work by appointment only** . **There will be a $25.00 convenience fee in addition to your copay for walk ins. This will be due a the time of service**

_____ **SICK VISITS**: If your child is sick, please make an appointment as early in the day as possible. We work by appointment only; *no walk-ins*. Patients arriving later than 20 minutes after the scheduled appointment time will have the option to reschedule or wait for the next available appointment that day. Please be courteous and notify us as soon as possible if you will not be keeping your appointment, so that we may offer the appointment time to another sick child.

_____ **HEALTH CHECKS**: Try to schedule the health check appointment for your child in advance. This will enable us to accommodate your schedule and allow your child's physician to spend ample time answering your questions and evaluating your child. **Patients arriving late (20 minutes after scheduled appointment time) will need to reschedule.** We understand that situations arise where you cannot keep an appointment. Kindly notify us 24 hours in advance if you are unable to keep an appointment, or you will incur a missed appointment fee of $50.

_____ **NO SHOW / MISSED APPOINTMENTS**: **Missed appointments will be charged a $50 "No Show Fee,"** These fees are not covered by your insurance. To avoid such fees please attend all scheduled appointments or call our appointment line at least 24 hours in advance to cancel the appointment.

_____ **IMMUNIZATIONS**: The Providers of this practice have made it policy to immunize ALL patients of this practice. **If it is your choice not to immunize your child(ren), you will be asked to find a new pediatrician.**

_____ **SATURDAY HOURS**: During specific seasons we provide Saturday morning hours in order to see your SICK child. Please call our office as early as possible to schedule an appointment. Phones are answered beginning at 9am. No walk-ins please.

_____ **SIBLING POLICY**: If you have another child with you today who is ill and is not originally scheduled to see the doctor, please immediately notify the front desk so that we may try to accommodate your child. DO NOT wait to inform us after you have entered the exam room.

_____ **ZERO TOLERANCE:** We strive to create a relationship of mutual respect for each other and our families that we serve. Verbal abuse will result in immediate dismissal from our practice.

_____ **SureScripts Prescription History:** I consent for my provider to access my child's prescription history via the electronic data base.

(Please turn over to complete form)

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_____ **NURSE PHONE CALLS**: The nurse line receives a high volume of calls. For your convenience, there is a voice mail system on this line. Please leave your name and phone number and spell your child's name and date of birth. One of our nurses will return your call as soon as possible. Morning calls are returned by 12:30pm, and afternoon calls by 5pm.

_____ **PRESCRIPTION REFILLS**: For medication that cannot be called in, please notify us **72 hours in advance** for picking up a prescription. The nurse will call in other medication refills as quickly as possible

_____ **MEDICAL/IMMUNIZATION RECORDS**: Please give a minimum of **72 hours** notice for completion of school forms. This includes immunization records and physical forms. For a copy of the full chart, a medical record release form must be signed. Once we have the signed release form, there is a minimum of **72 hours** before these records become available. If a second release is requested a $25 charge will apply.

If you are a new patient or have changed pediatricians or have received immunizations from the Health Department, please check with our staff to make sure we have your child's immunization records on file. In the instance your child's immunization records are not found or are not shown "up-to-date", it is your responsibility to obtain the missing records. We highly recommend that you keep a personal copy of your child's immunization records – we would be happy to make a copy for you!

_____ **INSURANCE**: To properly file your insurance claim(s), we must obtain a current copy of your child's insurance card **each time you visit our office**. This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof-of-insurance, payment will be expected at the time of service. Further, **if you provide us with incorrect insurance information, you will be responsible for the bill. If incorrect insurance information is given that requires a claim to be re-filed, there will be a $35 re-filing fee.**

- It is your responsibility to contact your insurance company and find out whether or not our Doctors are participating physicians within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our doctors may participate in only one of these areas, not in all.
- It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your own insurance policy.
- The following circumstances may result in you being billed directly:

~ we are not participating physicians in your plan; insurance coverage is not in effect because of the date of visit
~ non-covered lab work is ordered/performed
~ or a non-covered service is performed or denied for the reason "not medically necessary"

- Co-payments are collected up front and are due at the time of service by the person bringing the patient for the visit. If you do not have your co-pay we will bill you for a $15 administrative fee. If you have a deductible plan, 80% of the visit is due at the time of service

_____ **PREMISSION TO TREAT:** If someone other than the parent or guardian is bringing the patient**, a notice stating approval of the visit must be signed by the parent/guardian and presented at check-in. Also please ensure that you send payment for the visit.**

_____ **REFERRALS**: Referrals may be needed for specialists, emergency room visits, urgent care visits, etc. It is your responsibility to determine if your insurance requires a referral for health care visits outside of our office. If you do need a referral, please contact our office with an appointment date and time. We need **3 working days** to obtain a referral from your insurance.

_____ **LABS X-RAYS, OR OTHER AMBULATORY CARE SERVICES**: If labs, x-rays, or other ambulatory care services are required beyond your office visit, **it is your responsibility to know where your insurance company covers you to go for these services**. Each insurance company contracts with different companies.

I have read and understand the above stated policies, procedures, and notices.

Child's Name_____

Print Name_____

Relationship to Child_____

Signature _____ Date _____

Patient Registration Form
Pediatric Associates of Lawrenceville, LLC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY PRACTICE

By signing this authorization, I authorize Pediatric Associates of Lawrenceville, LLC (PAL) to use/or disclose certain protected health information (PHI) about_____.
(Child's Name)

This authorization permits PAL to use and/or disclose the following individually identifiable health information (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purposes:

Insurance information, further medical care, immunization forms to schools, daycare, college forms, camp forms ,sports physical forms, and to call prescriptions to pharmacy.

*Other:*_____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire in 365 days. At which point you will be asked to review and sign an updated copy.

The Practice _____ will _____**X**____ will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from PAL. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

755 Old Norcross Road
Lawrenceville, Georgia 30046

I acknowledge receipt of the Notice of Privacy Practices of Pediatric Associates of Lawrenceville, LLC.

Signed by:_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Date

As the personal representative, I have the authority to act for the Patient because I am the Patient's _____
(relationship to Patient)