How Did You Hear About Us?

Please list all that apply

1. FRIEND/WORD OF MOUTH ___________________________________

2. INTERNET SEARCH ____

3. OBGYN/HEALTHCARE PROVIDER _____________________________

4. COMMUNITY EVENT/FESTIVAL _______________________________

5. FACEBOOK PAGE OR AD ____________________________________

6. MAGAZINE AD ____

7. CHILD CARE CENTER OR SCHOOL ____________________________

8. OTHER ____

We Welcome Any Comments You May Have:

____

____

____

____

____

____

2920 Marietta Hwy, #142 Canton, GA 30114 (770) 704-0057 FAX (770) 704-0223

PATIENT REGISTRATION INFORMATION

Patient Name ______ **Date of Birth** ______ **Sex** ______ **Social Security Number** ______

Street Address ______ **City** ______ **State** ______ **Zip** ______

Home Phone ______ **Mobile** ______ **Email** ______

Race o White o Asian o Other (Multi-Racial) o Unknown
o Black o American Indian o Hawaiian/Pacific Islander o Decline To Answer

Ethnicity o Hispanic/Latino
o Not Hispanic/Latino
o Other______________________________

Primary Language o English
o Spanish
o Other ______________________________

Primary Contact Name ______ **Date of Birth** ______ **Sex** ______ **Social Security Number** ______

Street Address (if different from patient) ______ **City** ______ **State** ______ **Zip** ______

Home Phone ______ **Mobile** ______ **Email** ______

Relationship o Biological Mother/Father o Step Mother/Father o Adopted Mother/Father
o Foster Mother/Father o Legal Guardian o Other:________________

Live With Patient o Yes o No

Employer ______ **Employer Phone #** ______

Secondary Contact Name ______ **Date of Birth** ______ **Sex** ______ **Social Security Number** ______

Street Address (if different from patient) ______ **City** ______ **State** ______ **Zip** ______

Home Phone ______ **Mobile** ______ **Email** ______

Relationship o Biological Mother/Father o Step Mother/Father o Adopted Mother/Father
o Foster Mother/Father o Legal Guardian o Other:________________

Live With Patient o Yes o No

Employer ______ **Employer Phone #** ______

Emergency Contact Information – Please list someone that does not live with you.

Emergency Contact Name ______ **Best Phone #** ______ **Alternate Phone #** ______

Relationship: ___________________________

Please list the names of any siblings – List only children for which the above family dynamics apply. Continue on back.

Child's Name ______ **Date of Birth** ______ **Sex** ______ **Social Security Number** ______

Child's Name ______ **Date of Birth** ______ **Sex** ______ **Social Security Number** ______

Child's Name ______ **Date of Birth** ______ **Sex** ______ **Social Security Number** ______

____
Print Name Parent/Guardian

____ **Date** ______________
Signature of Parent/Guardian

DV PEDIATRICS, LLC FINANCIAL POLICY

Thank you for choosing DV 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. Due to the expense of billing, a $25 convenience charge will be added, to patients whose co-pay is not paid on the day of service. For your convenience, we accept cash, check, and Visa/MasterCard (including debit cards).

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 superbill, 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 superbill 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 for 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.

Even though you have health insurance, you as the guarantor are responsible for payment of all services provided by DV Pediatrics. Therefore it is your responsibility to notify DV Pediatrics immediately of any insurance change, in order to ensure the correct insurance carrier is billed for services rendered. If there is a change in your insurance company please ensure that we are listed as PCP, if a PCP is required to receive payment.

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, LATE FEES, and COLLECTIONS FEE
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. A late fee of $20 is applied to any item unpaid after insurance had adjudicated the claim (or 60 days from the date of service, whichever is less). Any delinquent account referred to collections will have a $300 collections charge applied. In addition, you are responsible for all legal fees, attorney fees, collection cost, and any miscellaneous expenses related to the collection of delinquent accounts.

PATIENTS WHO ARE NOT ACCOMPANIED BY A PARENT OR GUARDIAN
For unaccompanied patients, non emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard (including debit cards) or payment by cash or check at the time of service.

MISSED APPOINTMENTS
Missed appointments are very disruptive to our office. They also deprive others from an appointment to see the doctor. If you repeatedly miss scheduled appointments, you may be asked to seek medical care elsewhere. Please be courteous to those patients who need to be seen! A $25 No-Show fee will be charged for missed appointments.

WALK-IN APPOINTMENTS
In an effort to better serve our patients in a timely manner, we are asking that you **not** walk into the office without an appointment. Walk-in patients will be triaged and an appointment time made. In order to serve our patients, appointments are seen before any walk in appointments UNLESS an emergency exists with the walk-in patient A $25 convenience charge will be added and due with any other charges (co-pay, co-insurance, deductibles, etc.) at the time of service. (NOTE: If a child is being seen that day and the parent/guardian requests that we see a sibling/other child at the same time without a prior appointment, that child will be considered a walk-in and subject to this walk-in appointment policy.)

RETURN CHECK FEES
A $25 processing fee will be charged for checks returned as insufficient funds, stop payment on an issued check and checks drawn on a closed account. This charge is applied to your personal account balance and must be paid within 14 days of notification to avoid

further action. Any family account that has a history of more than two returned checks for insufficient funds will require cash or approved credit card payments for all visits thereafter.

DELINQUENT ACCOUNTS

If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Practice Administrator prior to your visit. Failure to resolve any past due accounts including any returned checks will result in referral to a collection agency.

Any family whose account is forwarded to a collection agency will be dismissed from our practice. If you are on a plan that requires you to be assigned to a Primary Care Physician (PCP) then a copy of the dismissal letter will be sent to the insurance company so they will know to reassign you to another PCP.

TRANSFERING OF MEDICAL RECORDS

Because there are frequent changes in health insurance coverage and participating providers, it is often necessary for patients to ask that their medical records be transferred to another physician's office. An immunization record and problem list can be provided at no charge. Otherwise, there will be a $25 administration fee charged for each child's records to be transferred.

NURSE FEE

Any procedures performed by the lab nurse (strep screens, lab work, hearing and vision, etc.) that do not require a face-to-face visit with the physician will incur a nurse fee in addition to the procedure performed. All appropriate co-payments will apply.

DIVORCE, SEPARATION, AND CUSTODY AGREEMENTS

DV Pediatrics will not be party to custodial, separation or financial disputes relating to individuals with regard to minor children to whom services are provided. The individual who requests the medical services and signs the financial agreement is responsible for any balance due. All co-pays, co-insurance, and deductible, if applicable, will be collected at the time services are rendered from the individual requesting the medical services for minor child/children. We will not call the other parent for consent. The physician will discuss the minor's medical information with the accompanied parent at the time of the visit. DV Pediatrics will provide a copy of any medical records requested, although we reserve the right to charge a fee. Both parents have access to the minor child's medical records, unless there is a court order that specifically mandates only one of the parents have the right to authorize medical treatment and release of the minor's medical records. We reserve the right to discharge any patient from DV Pediatrics if an issue comes between the (divorced/separated) parents which would disrupt our practice. We maintain that divorce, separation, and custody agreements should not enter into the medical care of a child; such matters should remain between the parents.

CHECK OUT

All patients are asked to please check out before leaving the office. It is unlawful to intentionally walk out without satisfying your financial obligations after treatment has been rendered. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

PATIENT FINANCIAL INFORMATION

______________________ ______________ ______ ______________________
Patient Name ***Date of Birth*** ***Sex*** ***Social Security Number***

Primary Insurance Information

______________________ ______________ ______________________
Primary Insurance Name **ID #** **Group #**

______________________ ______________ ______ ______________________
Subscriber's Name **Date of Birth** **Sex** **Social Security Number**

Relationship
- o Biological Mother/Father
- o Step Mother/Father
- o Adopted Mother/Father
- o Foster Mother/Father
- o Legal Guardian
- o Other:________________

Secondary Insurance Information

______________________ ______________ ______________________
Secondary Primary Insurance Name **ID #** **Group #**

______________________ ______________ ______ ______________________
Subscriber's Name **Date of Birth** **Sex** **Social Security Number**

Relationship
- o Biological Mother/Father
- o Step Mother/Father
- o Adopted Mother/Father
- o Foster Mother/Father
- o Legal Guardian
- o Other:________________

Financial Guarantor – This is the person that will receive Billing Statements, typically by mail. If listed as contact on the Registration page, then just complete the name.

Parents/Guardians – DV Pediatrics, LLC will not get involved in domestic situations regarding medical payment issues, including who receives the Billing Statement. You must agree on this and work out arrangements amongst yourselves regarding payment issues.

______________________ ______________ ______ ______________________
Financial Guarantor Name **Date of Birth** **Sex** **Social Security Number**

______________________ ______________ ______ ______________
Street Address (if different from patient) **City** **State** **Zip**

______________ ______________ ______________________________
Home Phone **Mobile** **Email**

Relationship
- o Biological Mother/Father
- o Step Mother/Father
- o Adopted Mother/Father
- o Foster Mother/Father
- o Legal Guardian
- o Other:________________

Live With Patient o Yes o No

For all insurance policies, including Medicaid, you are responsible to complete any and all requests for information from them. If not completed your insurance may become invalid, claims denied, and you will be held responsible for your charges.

We must have a copy of your current insurance card on file. You may be held financially responsible for all charges if you fail to provide a current insurance card at time of service.

_______ (Initial) I understand the above statements regarding my responsibilities.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I irrevocably assign and transfer to DV Pediatrics, LLC all insurance benefits for payment of all covered medical/surgical services rendered. I authorize payment directly to the Providers of DV Pediatrics, LLC under the terms of my insurance. I understand that I am financially responsible for all insurance covered (allowed) charges whether or not paid by my insurance. This includes co-pays, deductibles, and co-insurance amounts. I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.

____
Print Name

____ **Date** ______________
Signature of Parent/Guardian

NOTICE OF PRIVACY PRACTICES (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

DV PEDIATRICS DUTIES REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, DV Pediatrics has certain duties related to your protected health information, including:

- DV Pediatrics is required to maintain the privacy of protected health information.
- DV Pediatrics is required to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- DV Pediatrics is required to abide by the terms of the privacy notice that is currently in effect.
- DV Pediatrics reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

USES AND DISCLOSURE OF HEALTH INFORMATION

TREATMENT. DV Pediatrics may use and disclose your protected health information for treatment and to provide you with treatment related health care services. For example, we may share test results with other health care providers outside of our office for confirmation of a diagnosis.

PAYMENT. DV Pediatrics may use and disclose your protected health information so that others or we may bill or receive payment from you, an insurance company, or a third party for the treatment and services we provide. For example, we may give information to your health plan so that they will pay for your treatment.

HEALTH CARE OPERATIONS. DV Pediatrics may use and disclose your protected health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or your health plan that is evaluating our care.

OTHER USES AND DISCLOSURES. DV Pediatrics may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Providing you with information related to your health;
- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process;
- Research activities;

- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to public or private disaster relief agencies; or
- Informing a family member, other relative, or close personal friend when: Information is relevant to the individual's involvement with your care;
- Notification of your location, general condition or death;
- To assist in your heath care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.).

AUTHORIZATION FOR OTHER USES. DV Pediatrics will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

CELL PHONE AND AUDIO/VIDEO RECORDING POLICY

When you step into our office, your child's healthcare is our number one priority. That is why we ask that you please refrain from using your cell phone once you enter the office and for the remainder of the visit. If you must take a call, or have an important call to make, please step outside to do so.

Parent agrees to turn off all cellular phones/equipment upon entering the clinical area and in exam rooms. Use of cellular equipment interferes with wireless technology utilized within the office. The doctor/medical provider reserves the right to terminate the interaction if parent/patient uses their cell phone.

No audio or video recording of any kind for any reason is allowed in the office.

BEHAVIOR

DV Pediatrics has a zero tolerance policy against aggressive behavior, unreasonable expectations, bullying profanity, lying and verbal abuse towards our staff from patients and their family members. Any display of this behavior will subject you to being terminated as a patient from this Office.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, DV Pediatrics is not obligated to agree to requested restrictions;
- Receive confidential communications of protected health information;
- Inspect and copy your protected health information with some limited exceptions, subject to copying fees;
- Amend your health information;
- Receive an accounting of disclosures of your health information;
- Obtain a copy of this notice.

CONCERNS - If you believe your privacy rights have been violated, you may make a complaint by contacting DV Pediatrics, Office Manager, 2920 Marietta Hwy, Suite 142, Canton, GA 30114, 770-704-0057 or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

MISSED APPOINTMENT POLICY

Dear Parent:

We are delighted that you have selected DV Pediatrics to provide healthcare for your children. We pride ourselves on providing family oriented care that is the most up to date pediatric care available. As you are aware most medical problems can be handled during routine office hours. The office is open Monday through Friday, 8 AM until 5 PM. Please call 770-704-0057 if you need to make an appointment.

In the event that you need assistance, our office hours' calls are staffed by pediatric trained nurses at Rite Call through Children's Healthcare of Atlanta. The phone number for after hours' calls is 770-704-0057. If you require urgent attention after hours we suggest you consider the Children's Healthcare of Atlanta offices at Barrett Parkway. If your child needs immediate medical attention please call 911 or take your child to the nearest emergency room.

Our office believes that all children deserve medical care. As you know you are an essential part of the success of your child's medical care. In our attempt to provide care for your children we have developed the following clinic policies regarding missed appointments:

- You are required to give at least 24 hours notice if you are unable to keep an appointment.
- If you give less than 24 hours notice you will billed a no-show fee of $25.00.
- If you arrive over 15 minutes late for an appointment you may be asked to reschedule.
- If you arrive repeatedly late for your appointments you will be asked to reschedule. You may also be asked to find a new doctor.
- If your child misses an appointment you will be billed a $25.00 no-show fee.
- If your child misses more than 1 appointment in a 12 month period without proper notice, you may be asked to find a new doctor.
- If your child misses 3 appointments in a 12 month period you WILL be asked to find a new doctor.

Again we consider it a privilege to provide care to your child. Should you have any questions or suggestions please do not hesitate to call.

Policy on Co-Pay Requirements When A Sick Visit Is Added To A Well Child Visit

AT DV Pediatrics, we believe that Well Child Check visits are very important in addressing potential health concerns, keeping children properly protected against diseases, and discussing normal and unusual development. Generally speaking there are no co-pay requirements for a Well Child Visit. (That rule does not necessarily apply to a self-funded insurance plan).
Acute or chronic (sick) care performed with a Well Child Visit will result in an additional office charge that most likely will result in a copayment charge as required per your insurance policy.
A "typical" Well Child Visit may include, but not limited to:

- Check growth and development
- Physical assessment
- Immunizations
- Parental concerns about growth and development
- Age specific exams may include – hearing and vision screening; lead assessment and screening; M-CHAT questionnaire for autism, and other developmental screens/questionnaires as necessary

Acute (sick) illnesses include but not limited to – Bronchiolitis, pink eye, croup, common cold, dehydration, ear infection, rashes, eczema, fever, gastrointestinal infections/diarrhea, flu, sinusitis, urinary tract infection, medication modifications (asthma, ADD/ADHD, etc.), and vomiting. Chronic illness includes but not limited to allergies, asthma, ADHD, and diabetes.

Generally speaking just a refill of medication with no adjustment for chronic illness will not result in an additional charge. Changes in chronic illness health care medication will result in additional office visit charges for which a copayment may be required.

DV Pediatrics is required under contract with your insurance carrier to collect co-pays at the time of medical service, most commonly sick visits. You will be charged a co-pay if you either request, or approve, treatment for an acute or chronic illness during a Well Child Visit. Such a request constitutes a Sick Visit, in addition to the Well Child Visit.

Your insurance policy determines the co-pay requirements. If you are unable to or refuse to pay your co-pay, you may be asked to reschedule your appointment, or an additional $25 charge will apply according to DV Pediatrics, LLC Financial Policy. Contact your insurance carrier if you have questions specific to your policy's co-pay requirements plus any individual co-insurance and deductible limitations.

We will gladly bill you later for your copayment for an additional $25 charge.

PATIENT AUTHORIZATION SIGNATURES

Your Child(ren)s Name:

Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number

Please initial all applicable boxes.

Initial	
	Financial Responsibility I have received a copy of DV Pediatrics Financial Policies Statement. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can requested another printed copy I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment of services rendered at DV Pediatrics. I am responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that DV Pediatrics is not responsible for knowing what services my plan covers and does not cover. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Privacy Practices I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA) regarding the use and disclosure of my health information. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Missed Appointments I acknowledge that I have received a copy of the Missed Appointment Policy. I understand that DV Pediatrics, LLC will attempt to confirm appointments when administratively reasonable to do so. However I acknowledge it is my responsibility to keep up with my appointment times, and to notify DV Pediatrics if I am unable to keep that appointment, or be subject to a $25 per patient per appointment missed appointment charge. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Policy on Sick Visit Co-Pays When Added To Well Child Check I acknowledge that I have received a copy of the DV Pediatrics, LLC policy statement regarding Co-pay requirements when a Sick Visit is added to the Well Child Visit. I acknowledge that failure to pay co-pay at the time of service may generate an additional $25 patient responsible charge. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Authorization for Release of Information I hereby authorize DV Pediatrics to release necessary information for the following reasons: to other physicians for continuing professional care; to any insurance company or their representatives; or otherwise as allowed by law. I release DV Pediatrics from any liability for the release of information, and IO understand authorization is irrevocable and is not limited in time.
	Release of Data for e-Prescribing I hereby authorize DV Pediatrics, LLC to exchange prescription data with any/all prescription networks to facilitate the care of my child(ren) named above. This will include but not limited to medication history check, prescription eligibility coverage, generic vs. branded drug costs, drug interaction verification. This authorization is not limited in time.

Initial	Authorization for Care/Treatment
	Authorization for Care/Treatment I understand that my child(ren) may require medical treatment when I am not able to be present. In my absence I give the individual(s) listed below my permisiton to authorize any and all medical treatment(s) for my child(ren). **Individual(s) Name** ______ **Relationship To Patient** ______ ______ ______ ______ ______ ______ ______ Furthermore in my absence, I give permission to DV Pediatrics, LLC and its entire staff to examine and provide emergency treatment to the child listed above. In addition, the physicians/clinic has my permission to refer my child's emergent care and treatment to the appropriate service for the treatment of illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child's care whether or not services are covered by insurance. This authorization is not limited in time.
	Consent To Call With this consent I authorize DV Pediatrics, LLC to call my home, or other location that I specify, and leave messages regarding appointment reminders, insurance items, financial information, or any information pertaining to my child's clinical care, including lab and x-ray results. Please indicate how you prefer to be contacted regarding the following (check one for each item): ***Medical Issues:*** o Home phone o Cell Phone Phone #____________________ ***Appointment Reminders:*** o Home phone o Cell Phone Phone #____________________ ***Appointment Recalls:*** o Home phone o Cell Phone Phone #____________________
	PHI Release Who do you authorize to receive your child(ren)'s Personal Health Information (who in your family do you authorize us to speak with, i.e. ; step-parents, babysitters, grandparents) from DV Pediatrics, LLC. If a person, other than the legal parent/guardian, is not listed below, they will not be able to gain access to your PHI, either written or verbal. **Individual(s) Name** **Relationship To Patient** ______ ______ ______ ______ Description of information that may be disclosed: ______ ______ You may revoke or terminate this authorization by submitting a written revocation. You should contact the Privacy Officer to terminate this authorization. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
	Reserved

____
Print Name Parent/Guardian

____ **Date** ______________
Signature of Parent/Guardian

CHILD MEDICAL HISTORY: Birth To 6 Months

Patient Name ______________________ **Date of Birth** ____________

Adopted o Yes o No
Fostered o Yes o No

Where was your child born? ______________________

Birth Weight:_________**lb**______**oz** **Birth Length:**_________**inches**

NEWBORN HISTORY – while in hospital	No	Yes	If YES - explain
Resuscitation at delivery (needed help to start breathing/crying)			
Premature infant			
Got vitamin K and / or eye ointment			
Feeding: Breast milk or formula? Or both?			
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening labwork (to check for infection)			
Elevated Bilirubin (jaundice)			
Circumcision			
First bowel movement after 24 hours?			
Heart Murmur			
Breathing problems			
Needed antibiotics while in nursery			
Other issues:			

MOTHERS PRENATAL HISTORY	No	Yes	If Yes - explain
Was this an assisted conception (had to have help getting pregnant)?			
Was this a High Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
When did you start prenatal care?			How many weeks?
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before born?			
Water broke more than 24 hours before delivery?			
Did you have antibiotics or other medications during labor?			
Was your labor induced (started by medications)?			
Was this delivery vaginal or by C-section?			
Was there meconium (green bowel movement) present when your water broke?			
Did you take prescription medicines while pregnant?			
Was the baby breech?			
Other Issues:			

Patient Name:___________________________________

SOCIAL HISTORY	No	Yes	Details
Lives with both mother and father in same house.			
Non-intact home – who has primary physical custody?			Lives with?
Does non-custodial parent have visitation rights?			
Are there siblings who live in same house?			
Are there pets in the home?			
Does your child ride in a car?			
Does anyone in your home smoke?			
Is there a gun in your home?			
If yes, is it unloaded and stored in a locked cabinet?			
Do you have a pool?			
If yes, is then pool enclosed by a 4 sided fence?			
How old is the home/apartment you live in?			Years
Does your home have smoke detectors?			
Does your drinking water have fluoride?			
Has your child ever been physically hurt by an adult?			
Have you or are you planning on traveling outside the US?			
Has anyone visited you form a foreign country?			
Does anyone in close contact with your child have HIV/Aids or use IV drugs?			
Has anyone in close contact with your child been in prison, institutionalized or homeless in the last 2 years?			

Please check if your child has/had problems with the following:			
☐ Anemia	☐ Reactive Airways	☐ Kidney infections/UTI	☐ Serious injuries
☐ Seizures/Convulsions	☐ Wheezing	☐ Weak urine stream	☐ Broken bones
☐ Headaches	☐ Abdominal pain	☐ Skin diseases	☐ Vision problems
☐ Pneumonia	☐ Persistent diarrhea	☐ Chronic ear infections	☐ Crossed/lazy eye
☐ Tuberculosis/TB	☐ Constipation	☐ Sinusitis	Other (Please list)
☐ Asthma	☐ Nausea/vomiting	☐ Hearing problems	
☐ Sleep	☐ Hay fever/allergies		

MEDICATIONS: (Prescription; Over The Counter; Vitamins; Herbs; Etc.)			
Drug Name	Dose	Drug name	Dose

PATIENT ALLERGIES: ☐ None (If yes, list name and type of reaction)			
Allergy	No	Yes	Reaction/Type
Medications (list)			
Foods (list)			
Insects (list)			

Patient Name:________________________________

OTHER	No	Yes	
Has your child ever been hospitalized?			
If yes list dates, location, reason			
Has your child ever had surgery?			
If yes list dates, location, reason			
Dos your child see any specialists? (list)			

FAMILY HISTORY: Have any of the child's parents, grandparents or siblings had any of the following:

Illness/Condition	No	Yes	If Yes – Please check which biological Parent						
						Maternal		Paternal	
			Mom	Dad	Sibling	GM	GF	GM	GF
Anemia									
Anxiety Disorder/Depression									
Asthma									
Bleeding Disorders									
Cancer (type)									
Diabetes									
Drug or Alcohol Abuse									
Elevated Cholesterol									
Epilepsy or Convulsions									
Gastrointestinal Disease/Disorder									
Glaucoma									
Hay fever/Nasal Allergies									
Hearing Disorder									
Heart Disease									
High Blood Pressure									
Hip problems from Childhood									
Immunity Disorder									
Kidney Reflux									
Lazy Eye/Crossed eyes									
Liver Disease									
Mental Illness									
Neurological Issue Incl ADD/ADHD									
Strokes									
Thyroid Disorder									
Vision Disorder									
Other Issues:									

Do you have any concerns regarding your child's health we need to know?

Authorization To Release Information

Name Last	First	Middle	Maiden/Other	Date of Birth
Address	**City**	**State**	**Zip**	**Telephone Number**

I authorize and request:	**To Release To:**
____________________ ____________________ ____________________ Phone __________________ Fax __________________	**DV Pediatrics, LLC** **2920 Marietta Hwy, #142** **Canton, GA 30114** **(770) 704-0057**

The following information: (Check those to be used/disclosed)

- o Dates
  From ________________ To ________________
- o Discharge Summary
- o History and Physical
- o Operative Report
- o Pathology Reports
- o Laboratory Reports
- o Radiology Reports
- o Progress Reports
- o EKG Reports
- o ED/UC Reports
- o ________________

The purpose of this disclosure is: (Check one or more of the following)

- o Continued Medical Care
- o Insurance Processing
- o Disability Determination
- o Legal
- o Other ________________________________

I understand that a photocopy of this authorization shall be considered as valid as the original. I may inspect at no charge, and arrange for photocopies/electronic copies for a reasonable charge, of the record or information that is to be used or disclosed, by contacting a DV Pediatrics, LLC medical record department. I may receive a copy of this authorization. I further understand that this authorization shall be valid for 180 days or until the purpose of the request is fulfilled, unless otherwise stated: ____________________________. I understand that I am under no obligation to sign this form, and that, with certain exceptions, health care providers may not condition treatment, payment, or enrollment or eligibility for health plan benefits on obtaining an authorization. Exceptions include situations where authorization was sought for research-related treatment, or if the provision of healthcare is only for the purpose of creating protected health information for disclosure to a third part, or health plan enrollment or eligibility. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that if I refuse to authorize release of information required to process insurance reimbursement, I may be financially responsible for services. Consequences of refusal to consent, if any, include dismissal ____________________. This authorization may be revoked by me at any time through written notice to DV Pediatrics, LLC, except to the extent that information has already been released in reliance upon the authorization. Revocation of this authorization will be effective following receipt of the written revocation by DV Pediatrics, LLC. Information released pursuant to this authorization could potentially be re-disclosed by the recipient and no longer protected by HIPPA or other privacy laws.

I understand that my medical record and information in connection with the organization / hospital / treatment date(s) stated above may contain reports, records or information about mental health, developmental disabilities, alcohol and/or drug abuse, acquired immune deficiency syndrome (AIDS) / HIV test results and / or information, intoxication tests, and / or fetal monitor traces.

____________________________ __________________
Patient Signature Date Signed

____________________________ __________________
Signature of Parent/Guardian/Personal Representative (State relationship to patient) Date Signed

____________________________ __________________
Witness Signature Date Signed

Rev 11/12/2013