Lisa P. Allardice MD, F.A.A.P.
Mindy Scheible, NP-C
Diana Hess, CPNP
Carlie Frederick, APRN-BC

Pediatric Associates of LaGrange, P.C.

Today's Date: _____

P

Patient First Name: ☐ Middle Name: ☐ Last Name:

Mark the name patient goes by

Patient SSN: Patient DOB: Sex: M F

Bill Payer: Patient Lives With:

Address: Address:

City: State: Zip: City: State: Zip:

Mother's Cell Phone: - - Mother's Work Phone: - - Home Phone: - -

Father's Cell Phone: - - Father's Work Phone: - - Alt. Phone: - -

A

Mother's Name: Maiden Name: Mother's DOB:

Mother's Employer: Mother's SSN:

Father's Name: Father's SSN: Father's DOB:

Father's Employer:

Primary Insurance: ☐ Dad's Insurance ☐ Mom's Insurance ☐ Other:

Secondary Insurance: ☐ Dad's Insurance ☐ Mom's Insurance ☐ Other:

L

Number of people living in child's household Mother in Household: Y ☐ N ☐ Father in Household: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

S

Persons Allowed to bring child to office visits for treatment	Relationship to patient

PEDIATRIC ASSOCIATES OF LAGRANGE, P.C.
LISA P. ALLARDICE, M.D., F.A.A.P.
DIANA L. HESS, CPNP

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Associates of LaGrange, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates of LaGrange's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates of LaGrange reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Associates of LaGrange's Privacy Officer at 205 Calumet Center Road, LaGrange, GA, 30241.

With my consent, Pediatric Associates of LaGrange may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Associates of LaGrange may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Pediatric Associates of LaGrange may e-mail and/or text to me appointment reminders and patient statements. I have the right to request that Pediatric Associates of LaGrange restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Pediatric Associates of LaGrange's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Associates of LaGrange may decline to provide treatment to me.

I authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Associates of LaGrange, P.C., for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Name of Parent or Legal Guardian

_____

Print Patient's Name

PATIENT MEDICAL HISTORY

PATIENT NAME: _____

Please circle if your child has had any of the following:

Bronchiolitis	Kidney Disease	Blackout Spells	Congenital Heart Disease	Behavior Problems
Bronchitis	Kidney Infections	Brain Disease or Injury	Neurofibromatosis	Eye Problems
Persistent Cough	Problems Urinating	Cerebral Shunt	Tuberous Sclerosis	Skin Problems
Wheezing	Urinary Tract Infections	Headaches	Chicken Pox	Immune Problems
Whooping Cough	Urologic Malformations	Seizures	Mumps	Thyroid Problems
Allergies	Constipation	Staring Spells	Measles	Sleep Problems
Hay Fever	Diarrhea	Broken Bones	German Measles	Bleeding Problems
Sinusitis	Excess Weight Gain	Joint Problems	Malignancy or Bone	Eating Problems
Scarlet Fever	Excess Weight Loss	High Blood Pressure	marrow Transplant	Prematurity
Strep Throat	Frequent Vomiting	Treatment with medicine	Solid Organ Transplant	
Tonsillitis	Soiling Pants	known to raise blood	Poisoning	
Bed Wetting	Stomach Ache	pressure	Meningitis	

Please specify any allergies your child has had in the past: _____

Please list any medical problems, surgeries,specialists: _____

Please list all medications currently taken: _____

Hospitalizations: _____

Circle if your child had any of the following with baby shots (immunizations): High Fever, Seizure, Leg Swelling, Uncontrollable Screaming, Other _____

Pregnancy, labor, delivery and nursery: Was your pregnancy planned? Yes No

Circle if you had any of the following during pregnancy:

C-Section	Labor longer than 1 day	Hepatitis B or C	Other pain medicines
Reason for C-Section	Early labor	Syphillis	Kidney infections
_____	Vacuum	Gonorrhea	Other infections
Spinal/Anesthesia	Forceps	High blood pressure	Medicines other than
Infection or fever during labor	Group B Strep	Alcohol or drug abuse	prenatal vitamins
Water leaking > 1 day	HIV	Cigarette use	Cigarette Exposure

Circle it the baby had any of the following problems:

Problem right after birth	Infection	Jaundice	Longer hosp stay than you
Breathing problems	Low sugar	IV or IV antibiotics	Low blood count or anemia
Feeding problems	Heart murmur	ICU	Tube, bag or mask to breathe

What was the child's birth weight? _____ What was the child's Apgar scores? _____
Was the baby full term? If not, how many weeks early? _____ If child stayed in the ICU, where and how long? _____Problems while in ICU? _____
Any signs or symptoms of maternal/paternal depression since child's birth? Y/N Explain: _____

Family History: ***Circle in anyone in your family has any of the following:***

Y/N High cholesterol	Y/N Gallbladder disease	Y/N Seizures	Y/N Eye problems	Y/N Birth defects
Y/N High blood pressure	Y/N Hepatitis B,C	Y/N Migraines	Y/N Deafness	Y/N Cancer
Y/N Rheumatic Fever	Y/N Thyroid disease	Y/N Asthma	Y/N Allergies	Y/N Early death
Y/N Kidney stones	Y/N Diabetes	Y/N Cystic Fibrosis	Y/N Eczema	Y/N Mental disease
Y/N Congenital kidney disease	Y/N Overweight	Y/N TB (Tuberculosis)	Y/N Skin problems	Y/N Mental retardation
Y/N Kidney disease	Y/N Excessive weight gain	Y/N Abnormal fingers or toes	Y/N Cleft lip or palate	Y/N Behavior problems
Y/N Ulcers	Y/N Height less than 5' 0"	Y/N Joint disease	Y/N Bleeding problems	Y/N Learning problems
Y/N Bowel disease (Ileitis)	Y/N Height greater than 6'4"	Y/N Crippling arthritis	Y/N Leukemia	Y/N Reading problems
Y/N Liver problems	Y/N Immune problems	Y/N Sickle cell disease	Y/N Abnormal teeth	Y/N Hyperactivity/ADD/ADHD
Y/N Alcohol problem	Y/N Stroke	Y/N Blindness	Y/N Down's Syndrome	Other_____

Y/N Heart Attack (man less than 40 years/ woman less than 50 years)

Person Completing Form_____Date _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I, or the undersigned personal representative, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may be redisclosed and may no longer be protected by federal privacy regulations.

Patient Information:

Name: _____ Date of Birth: _____

The information requested will be disclosed by: _____

_____

_____

The information may be disclosed to:
Name: **Pediatric Associates of LaGrange, P.C.**
Address: **205 Calumet Center Rd. LaGrange, Ga. 30241**
Phone Number: **(706) 885-1961** Fax Number: **(706) 885-1963**

Information to be disclosed:

- ☐ Complete Medical Record
- ☐ Emergency Department Record
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation
- ☐ Progress Notes
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ Radiology Report
- ☐ Ultrasound Report
- ☐ Immunization Records
- ☐ Form 3231
- ☐ Ear/Eye/Dental Form
- ☐ Birth Record
- ☐ Drug/Alcohol Abuse Notes
- ☐ HIV-related Record/Notes
- ☐ Paternity Test Results
- ☐ Other _____

Purpose for disclosure: _____

I understand that this authorization will remain in effect for ninety (90) days after the authorization is signed and dated or whenever requested information is used/disclosed whichever first occurs. I also understand that I may revoke this authorization at any time by notifying in writing the Privacy Officer of Pediatric Associates of LaGrange, P.C. to whom this authorization was originally addressed, but if I do, it will not have any effect on actions that Pediatric Associates of LaGrange took before it received the revocation. Aside from this, I understand that upon expiration of the authorization, no further use or disclosure of the information will be made.

_____ _____
DATE SIGNATURE

If signed by Personal Representative, indicate authority to act for individual:

- ☐ Parent
- ☐ Guardian
- ☐ Health Care Power of Attorney
- ☐ Other

Original-Medical Record Copy
Copy-Patient/Patient Representative

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