Pediatric Associates of Brunswick

Stephen J. Thompson, M.D.
Amy Pavlou, M.D.
Helene Coyle, M.D.

Patient Information

Today's Date ____________________

Name ____ Date of Birth _______________

Male _____ Female _____ Race ____________ Ethnicity: Not Hispanic _____ Hispanic _____

Address _____________________________ City ____________ State _______ Zip _______

Home Phone _________________________ Cell Phone _________________________

Email Address: _____________________________ Preferred Language _______________

Emergency Contact (other than parent/guardian) ________________ Phone ____________

Mother/Guardian _________________________ DOB __________ SS# ______________

Employer _____________________________ Phone _____________________________

Father/Guardian _________________________ DOB __________ SS# ______________

Employer _____________________________ Phone _____________________________

Patient lives with: Mother Father Both Guardian/Other(Name): ____________________

Health Insurance Information

Primary Insurance ______________________ Name of Insured ______________________

Policy # ________________________ DOB/SSN of Insured ___/___/___ _____________

Secondary Insurance ____________________ Name of Insured ______________________

Policy # ________________________ DOB/SSN of Insured ___/___/___ _____________

Medicaid/Peachcare # ____

I hereby authorize Pediatric Associates of Brunswick to provide medical treatment to my child.

Signature ________________________________

I hereby authorize payment directly to Pediatric Associates of Brunswick for medical and or surgical benefits otherwise payable to me, but not to exceed the charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance.

Signature ________________________________

I hereby authorize Pediatric Associates of Brunswick to release to my insurance company any information required, including the diagnosis and records in the course of my examination or treatment.

Signature ________________________________

Date History Obtained ________________ Informant ____________________________

Patient Name ____________________________ Date of Birth ________________________

Perinatal History

Maternal Complications ____

Term ___________ Pre-Term ___________ (wks) Post-dates ___________(wks)

Weight __________ Delivery: vaginal ________ C-Section (reason) ___________________

Infant Complications: Breathing Problems ______ Jaundice ______ Infection ______

Seizures ______ Other ______________________________

Development: Sat ________ (mos) Crawled ________ (mos) Walked ________(mos)

First words (other than ma-ma, da-da) ________ (mos)

School History ____

Family History (State Relationship to Patient)

Heart Disease ________ Diabetes ________ Bleeding Disorders ________ Hypertension ________

Seizures ________ Allergies/Asthma ________ Strokes ________ Birth Defects ________

Cystic Fibrosis ________ Elevated Cholesterol ________ Anemia/Sickle Cell Disease ________

Learning Disabilities ________ Mental/Emotional Illness ________ Other (substance abuse, etc) ________

SIBLINGS:

Name	Sex	Age/Date of Birth	Health

Social History

Parents: Married ______ Divorced ______ Separated ______ Single ______

Who lives in household? ____

Daycare: ____________________________________

Patient History

Allergies: ____

Illnesses: ____

History of Chicken Pox: ____

Hospitalizations/Surgeries/Serious Injuries: ______________________________

Current Medications and Doses: ____

Patient Eligibility Screening Record

Vaccines for Children Program

Date ____________________

Child ____
Last Name First Name MI

Date of Birth __________________

Parent/Guardian/
Individual of Record ____
Last Name First Name MI

Provider ____

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.**

This child qualifies for vaccination with state-supplied vaccine because he/she:
(please circle one)

(a) is enrolled in Medicaid

(b) is American Indian or Alaskan Native

(c) does not have health insurance

(d) has health insurance that does not pay for vaccines

(e) is enrolled in PeachCare for Kids

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Due to any circumstances in the absence of the parent(s) I, ____________________
(Parent)

____________________ give my permission for the following person(s) to authorize

medical attention for my child/children ____________________________________.
(Child)

1. __________________________________ ____________________________
(Name) (Phone)

2. __________________________________ ____________________________
(Name) (Phone)

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Privacy Practice Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name of Patient ________________________________

Birth Date of Patient __________________________

Signature of Parent/Guardian __________________________

Date of Signature ____________________________

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Fax: (912) 265-6779

Authorization For Release of Information

Patient Name: ______________________________ **Date of Birth:** ____________________

Address: ____

Telephone Number: ______________________________

I authorize the release of medical information as indicated below:

FROM:

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

TO:

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

☐ I would like to pick up my records ☐ I would like records mailed to address listed above

What to Release: Please choose the records you would like released-

☐ Immunization Record
☐ All medical records
☐ Laboratory Reports
☐ Other- Specify______________________________

The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including HIV tests	☐ Yes	☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	☐ Yes	☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	☐ Yes	☐ No/NA

Purpose of the release: Please indicate the reason for this release-

☐ For another doctor:
- ☐ Moving
- ☐ Switching doctors
- ☐ Other: ______________________________

☐ Use in a lawsuit
☐ Follow-up related to an injury
☐ Personal use
☐ Other- Specify______________________________

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

☐ Please change the expiration date to last for ____________ days

I understand this authorization can be revoked at any time according to Pediatric Associates of Brunswick's privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of the release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Pediatric Associates of Brunswick and may potentially be re-disclosed by the party who received these records. Pediatric Associates of Brunswick, its employees and officers, and attending physicians are released for legal responsibility or liability for the release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

______________________________ ____________________
Signature of the parent/legal guardian Date