CUMMING PEDIATRIC Group growing with you

Established Patient Information Update

Child 1: Last Name_____________________________ First Name _______________________ MI______ D.O.B._____/_____/_____
Ethnicity: Hispanic Not Hispanic Unknown Race: Asian Black Hawaiian White Unknown M_____F_____

Child 2: Last Name_____________________________ First Name _______________________ MI______ D.O.B._____/_____/_____
Ethnicity: Hispanic Not Hispanic Unknown Race: Asian Black Hawaiian White Unknown M_____F_____

Child 3: Last Name_____________________________ First Name _______________________ MI______ D.O.B._____/_____/_____
Ethnicity: Hispanic Not Hispanic Unknown Race: Asian Black Hawaiian White Unknown M_____F_____

Child 4: Last Name_____________________________ First Name _______________________ MI______ D.O.B._____/_____/_____
Ethnicity: Hispanic Not Hispanic Unknown Race: Asian Black Hawaiian White Unknown M_____F_____

Address____ City___________________________ State_______ Zip____________

Pref. Language_______________________________ Child(ren) lives with/relation to_______________________________________

Preferred Pharmacy_________________________________ City__________________________ Phone______________________

Contact Information

Mother / Stepmother / Legal Guardian *(please circle one):*

Last Name____________________________ First Name________________________ MI_____ Date of Birth_____/_____/_____

Cell____________________ Wk__________________ Email______________________________ Lives with patient? Yes___ No___

How would this contact ideally prefer to be contacted? (circle one): Home / Work / Cell / Email

Address____ City__________________________ State_______ Zip____________

Biological Relation to Patient: (please circle) YES___ NO___ Relation to Patient_________________________

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

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Father / Stepfather / Legal Guardian *(please circle one):*

Last Name____________________________ First Name________________________ MI_____ Date of Birth_____/_____/_____

Cell____________________ Wk__________________ Email_____________________________ Lives with patient? Yes___ No___

How would this contact ideally prefer to be contacted? (circle one): Home / Work / Cell / Email

Address____ City__________________________ State_______ Zip____________

Biological Relation to Patient: (please circle) YES_____ NO_____ Relation to Patient_____________________________

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Emergency Contacts, *other than parents*: [**Will also be authorized to bring child(ren) to appointments.]

1:_____________________________________ Relationship_________________________ Ph_________________________

2:_____________________________________ Relationship_________________________ Ph_________________________

Additional Contact Questions:

Who should receive billing statements?_____

May all contacts have access to the patient's records electronically? Yes____ No____

If no, list who may have access_____

***If parents are divorced or separated please fill out this section:

Who has primary 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.

_____

_____

How did you hear about our office? ____Insurance ____Website ____Friend ____Other_____

_____ _____

Parent/Guardian Name (please print) **Relation to patient**

_____ _____

Parent/Guardian Signature **Date**

1800 Northside Forsyth Drive, Suite 460
Cumming, Ga 30041
Tel: (770)888-8888 Fax: (770)888-4502

Parent or Legal Guardian Consent Form

Patient Name: _____

Date of birth: _____/_____/_____

The following persons have my permission to accompany my child to appointments at Cumming Pediatric Group. I am aware that the office visits may include vaccinations, medications, referrals, or labs.

This form authorizes the following persons to receive information regarding my child's insurance or other medical care.

_____ Relation_____

_____ Relation_____

_____ Relation_____

Parent/Legal Guardian (Print Name)_____

Parent/Legal Guardian (Signature)_____ Date: _____

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CONSENT TO TREAT

Permission is hereby given for patient _____, date of birth_____ to receive any medical/surgical procedures, x-rays, drug or laboratory tests, medication or exam as may be deemed necessary by the physicians. In case of a minor, the consent below is given on his or her behalf.

Please initial:

_____ I hereby authorize Cumming Pediatric Group to obtain medical records from any other physician or medical facility necessary in the course of my child's treatment.

_____ By signing this document, I acknowledge I have received and read the Cumming Pediatric Group Notice of Privacy Practices and Individual Rights.

_____ I hereby authorize messages to be left on a voice mail system or answering machine concerning my child.

Parent/Legal Guardian (Print Name) _____

Parent/Legal Guardian (Signature)_____ Date:_____