Fields' Family Care

96 Tara Commons Drive · Loganville, GA 30052 · 770-554-0399

PEDIATRIC NEW PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ Place of Birth: _____

City, State, ZIP: _____ Social Security #: _____

Primary Phone: (_____) _____ Race: _____ Sex: Male Female

Secondary Phone: (_____) _____ Marital Status: Married Single Divorced Widowed

Mailing address: _____ Email: _____

_____ _____

Emergency Contact: _____ Relation: _____ Phone: (_____) _____

Do you have a living will? Yes No

Do you have a Power of Attorney? Yes No If yes, Name: _____

How did you hear about this practice? _____

Name of Parent or Guardian: _____ Relation: _____

Mailing Address: _____

Primary Phone: (_____) _____ Social Security #: _____

Primary Insurance Company: _____ Phone: (_____) _____

Claims Address: _____

Identification #: _____ Group #: _____

Name of person who holds this policy: _____ Relationship: _____

Policy holder's SSN: _____ DOB: _____

Secondary Insurance Company: _____ Phone: (_____) _____

Claims Address: _____

Identification #: _____ Group #: _____

Name of person who holds this policy: _____ Relationship: _____

Policy holder's SSN: _____ DOB: _____

FORMS MUST BE SIGNED & DATE

Signature: _____ Date: ____/____/____

Patient / Patient Guardian

Fields' Family Care

Pediatric Medical History Form:

Patient Name: _____ Date of Birth: _____

Family History:

- Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family member(s)? Maternal or Paternal?	Approximate age diagnosed
Thyroid:	_____	_____
Cancer (describe type):	_____	_____
Diabetes:	_____	_____
High Cholesterol:	_____	_____
Heart Disease:	_____	_____
Strokes:	_____	_____
Hypertension (high blood pressure):	_____	_____
Mental Illness (depression, anxiety, etc):	_____	_____
Drug or Alcohol Addiction: (If yes, specify drug or alcohol)	_____	_____

Social History: Circle the appropriate answers

Parents: Single Married Separated Divorced

Siblings: Please List: _____

How many people live in your home? Adults _____ Children _____

Is your child currently enrolled in daycare or school? No Yes

Does your child participate in regular exercise? No Yes

Tobacco Exposure**:** None Minimal Frequent
If frequent, does the family member smoke indoors or outdoors? _____

Does your child drink caffeine? No Yes

Any pets at home? No Yes

What is your water source? (i.e. well water, city water, etc.): _____

Do all family members use seat belts/ care safety sets? No Yes

Signature: _____ Date: ____/____/____
Patient / Patient Guardian

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Pediatric Medical History Form:

Patient Name: _____ Date of Birth: _____

Medical/ Birth History: (Please list dates of hospitalizations & surgeries)

Delivery: Vaginal Cesarean – Due to: _____

Was this child premature? No Yes – how manty weeks? _____

Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.?

No Yes – Please List: _____

Was/ Is this child breast fed? No Yes

Dis/ Does this child have any problems with breast feeding or formula feeding? No Yes

Hospitalizations? None Yes - Please List: _____

Surgeries? None Yes - Please List: _____

Drug Allergies? None Yes - Please List: _____

Any Chronic Illnesses? None Yes – Please List: _____

Present Medical Condition / Review of Systems: **Circle Yes or No**

Blood or bleeding disorders:	No Yes	Heart Disease:	No Yes	Mental Illness:	No Yes
Cancer:	No Yes	Hypertension:	No Yes	Respiratory disorders:	No Yes
Diabetes:	No Yes	Joint pain:	No Yes	Skin Disorder:	No Yes
Drug or alcohol addiction:	No Yes	Kidney Disease:	No Yes	Thyroid disorder:	No Yes
Gastrointestinal disorders:	No Yes	Liver Disease:	No Yes	Venereal Disease:	No Yes
Glaucoma – cataracts, etc.:	No Yes	Lower back pain:	No Yes	Other: _____	

If you answered yes to any of the above, please explain: _____

_____

Is there anything else that you would like to discuss with the practitioner? No Yes – Please List: _____

_____

Signature: _____ Date: ____/____/____

Patient / Patient Guardian

Fields' Family Care

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTATION

Patient Name: _____ DOB: _____

I, the undersigned, **authorize permission** for David A. Fields, MD, Family Care, PC to be able to discuss my medical health information with the following individuals (family members or friends):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Pharmacies for today's RX:

(Local) _____

(Mail Order) _____

I authorize Dr. David A. Fields' office to send un-encrypted emails to me, upon my request:

Email: _____

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for my healthcare related utilization review or quality assurance activities. I hereby assign and authorize payment to David A. Fields, MD, Family Care PC, of all medical and/or surgical benefits, including major medical benefits to which I am entitled to under any insurance policy or policies, under and self-insurance program, or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to David A. Fields, MD, Family Care PC, by any insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered effective and valid as the original. I understand that I have the right to receive a copy of this authorization**. I understand that an increase of 40% shall be added to any balance that is turned over to a collection agency. I understand that I will be charged a $25 fee for No Shows on appointments scheduled.** I, the undersigned, have had the opportunity to review a copy of David A. Fields, MD, Family Care, PC's Notice of Privacy Practices.

Signature: _____ Date: ____/____/____

Patient / Patient Guardian