

Pediatric Associates of Johns Creek, PC  
4310 Johns Creek Parkway, Suite 150  
Suwanee, GA 30024  
770-476-4020

## Patient & Family History

Your kindness in furnishing the following information will be appreciated.  
The information will be used in strict confidence to prepare your child's chart.

Today's Date \_\_\_\_\_

Child Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Please list the names and birthdates of other children \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Child's Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Would you like to receive our e-Newsletter? Y N

**Father's Full Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Ht** \_\_\_\_\_ **Wt** \_\_\_\_\_

**Father's Address** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Business Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Business Name** \_\_\_\_\_

**Education Level** \_\_\_\_\_ **Medical Problems:** \_\_\_\_\_

**Mother's Full Name** \_\_\_\_\_

**Birthdate** \_\_\_\_\_ **Maiden Name** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Ht.** \_\_\_\_\_ **Wt.** \_\_\_\_\_

**Mother's Address** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Business Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Business Name** \_\_\_\_\_

**Education Level** \_\_\_\_\_ **Medical Problems** \_\_\_\_\_

\*\*\*

Who is Responsible for the child's medical bills? \_\_\_\_\_

Child's Insurance Company \_\_\_\_\_

Insurance Policy # \_\_\_\_\_

Insurance Group # \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

**Patient History** *Please write the child's name/date of occurrence for any of the following:*

Allergies \_\_\_\_\_  
Asthma \_\_\_\_\_  
Allergy Shots \_\_\_\_\_  
Appendectomy \_\_\_\_\_  
Blood Disorders (IPT, SCA) \_\_\_\_\_  
Chicken Pox \_\_\_\_\_  
Convulsions \_\_\_\_\_  
Ear Infections \_\_\_\_\_  
Ear Tubes \_\_\_\_\_

Heart Concerns \_\_\_\_\_  
Mumps \_\_\_\_\_  
Pneumonia \_\_\_\_\_  
Roseola \_\_\_\_\_  
Rubella \_\_\_\_\_  
Tonsillectomy/Adenoidectomy \_\_\_\_\_  
Urinary Infections \_\_\_\_\_  
Other hospitalizations \_\_\_\_\_

**Family History** *Anyone in the family with the following:*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Lung Disease          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Bleeding Problems       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease       |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Convulsions or seizures | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Alcoholism            |
| <input type="checkbox"/> Cystic fibrosis         | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Drug Abuse            |
| <input type="checkbox"/> Other _____             |  | <input type="checkbox"/> Tobacco Use           |

*I hereby authorize these individuals to bring my child for medical care to and/or to be contacted in case of emergency by Pediatric Associates of Johns Creek.*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

\*\*\*

Please remember that effective insurance is not a guarantee of payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If this account is assigned to an attorney and/or collection agency for suit and/or collection, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Pediatric Associates of Johns Creek, PC  
The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed \_\_\_\_\_ Date \_\_\_\_\_