HAMILTON MILL PEDIATRICS
3619 BRASELTON HWY, ST 103 DACULA, GA 30019
P: 770-513-8882 F: 770-513-3545

CHILD REGISTRATION FORM

Patient Name: ________________________________ M / F Birth Date: _____ /_____ /_____

Patient Name: ________________________________ M / F Birth Date: _____ /_____ /_____

Patient Name: ________________________________ M / F Birth Date: _____ /_____ _____

Patient Name: ________________________________ M / F Birth Date: _____ /_____ /_____

Patient Lives With: ( )Both Parents ( )Mother ( )Father ( )Other:________________________________

Fathers Name:____________________________________
( )Single ( )Married ( )Separated ( )Widowed ( )Divorced

Street Address:______________________________________
City:____________________ Zip:______________________
DOB:____________________
Hm Ph:___________________ Wk Ph:______________
Cell Ph:___________________________________
Email:____
Employer:_______________________________________
Communication Preference: ( ) Home ( ) Work ( ) Cell

Mothers Name:____________________________________
( )Single ( )Married ( )Separated ( )Widowed ( )Divorced

Street Address:______________________________________
City:____________________ Zip:______________________
DOB:____________________
Hm Ph:___________________ Wk Ph:________________
Cell Ph:___________________________________
Email:____
Employer:_______________________________________

PRIMARY INSURANCE INFORMATION

Subscriber Name:_____________________________
Ins. Comp. Name:_____________________________
Group Plan:_________________________________
Employers Name:_____________________________
Ins. Comp. Address:__________________________
Ins. Comp. Phone #:__________________________
Group #:___________________________________
Insured ID:_________________________________

SECONDARY INSURANCE INFORMATION

Subscriber Name:_____________________________
Ins. Comp. Name:_____________________________
Group Plan:_________________________________
Employers Name:_____________________________
Ins. Comp. Address:__________________________
Ins. Comp. Phone #:__________________________
Group #:___________________________________
Insured ID:_________________________________

BIRTH HOSPITAL:___________________________________ **State:**_________________________
Previous Pediatrician:____
Phone#:________________________ **Fax#:** ____________________________ **(if available)**

PHARMACY INFORMATION:

Pharmacy Name:___________________________________
Phone#:___________________________ **Fax#:**____________________________
Address:____ **City:**____________________ **State:**______ **Zip:**_________

EMERGENCY CONTACT:___________________________________ **(other than parent/guardian)**
PHONE#:____________________________________ **RELATIONSHIP TO PATIENT:**__________________________

Financial Policy Statement

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

COPAYMENTS: Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies.

RETURNED CHECK FEE: Hamilton Mill Pediatrics accepts cash, personal check (in-state only), VISA, and MasterCard. There is a $25.00 service charge for returned checks.

BILLING: A $5.00 service fee with be added to any co-payment that is to be billed unless the balance of the co-payment is paid before the last day of the month. An additional $5 fee will be charged EACH month that the co-payment balance is not received.

OUTSTANDING BALANCES: Patients with an outstanding balance of 60 days overdue must make at least a partial payment, or arrangements for payment prior to scheduling appointments. We realize that people sometime run into financial difficulty and we are willing to work out payment arrangements.

INSURANCE: There are numerous insurance plans that we are contracted with so that we may be able to assist your health needs. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 90 days from the date of service, you will be expected to pay the balance in full. You are ultimately responsible for all charges.

REFUNDS: Overpayments will be refunded upon written request to the responsible party listed on the patient's account or will be held on the account as a credit for future payments.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time that was set aside for you. We feel that this is a very serious matter. Cancellations are requested 2 hours prior to the appointment. Any cancellation without at least a 2 hour notice will be considered a broken appointment. We reserve the right to charge for missed or late-canceled appointments. A $30.00 fee will be applied to the family account for each missed/late canceled appointment with in a family. Excessive abuse of scheduled appointments may result in discharge from the practice.

MEDICAL RECORDS REQUEST: There is a $15.00 charge for the copying and mailing/faxing of medical records for all patients (patients that have not been seen with in the last 2 years we will have to get their charts from storage). (Georgia General Assembly Unannotated Code 31-33-3)
Vaccination/Immunization records (3231 Form) retrieved from G.R.I.T.S. are $4.00 each

AGREEMENT

I have read and understand the Hamilton Mill Pediatrics Financial Policy. I agree to assign insurance benefits to the Hamilton Mill Pediatrics whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

If you need assistance or have questions, please contact the Practice Administrator between 9:00 am and 5:00 pm, Monday through Thursday, 9:00am and 1:00pm Friday at 770-513-8882.

Signature of Insured or Authorized representative: ____

Date: _________________________

Authorization for Release of Information

Authorization for release of information for ____

(Patient's Name) (DOB)

I, ____ hereby,

(Parent's name)

__ authorize Hamilton Mill Pediatrics to release information to:	__ authorize Hamilton Mill Pediatrics to obtain information from:
_______________________________________	_______________________________________
_______________________________________	_______________________________________
_______________________________________	_______________________________________

The following types of information from my records:
(ANY & ALL) / or:

____

I understand this authorization includes release of all medical records including HIV records, Psychiatric Drug/Alcohol abuse records, venereal disease, and any other statutory protected diseases. All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance hereof.
I also understand that once I have medical records transferred from this office, I may no longer have the option to return to this practice for medical treatment, the decision will be to the discretion of the practice.

______________________________________ __________________________________

Patient's signature (if 18 years or older)
Or Parent's signature (if patient under age of 18)

Relationship to patient
(if not signed by patient)

____

Date of Signature

*If transferring out of our office, Hamilton Mill Pediatrics, please state reason for leaving:

____Moving ____ Unsatisfied with practice _____ PCP Change _____Other

A Flat Fee of $15.00 is charged for all retrieval/copying/postage per patient medical record.

Paid: __________ **Date:** _____________

Patient Consent for Use and Disclosure of Protected Health Information

Patient's Name: ____

I hereby give my consent for R. David Thomson, MD, LLC, doing business as Hamilton Mill Pediatrics, to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (R. David Thomson, MD, LLC'S Notice of Privacy Practices provides 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. R. David Thomson, MD, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to R. David Thomson, MD, LLC at 3619 Braselton Hwy, Suite 103 Dacula, GA 30019.

With this consent, R. David Thomson, MD, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, lab result cards marked Personal/Confidential, and patient billing statements.

With the consent, R. David Thomson, MD, LLC may e-mail to my home or other alternative location any item that assist the practice in carrying out TPO, such as appointment reminders, lab results, and patient statements. I have the right to request that R. David Thomson, MD, LLC 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 to R. David Thomson, MD, LLC'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 disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, R. David Thomson, MD, LLC may decline to provide treatment to me.

____ ______________________

Signature of Patient or Legal Guardian Date

____

Printed Name of Patient of Legal Guardian

Acknowledgement of Notice of Privacy Practices

Patient's Name: _____________________ Date of Birth: _________

I, ___________________________, have been made aware of the office copy of the Notice of Privacy Practices for R. David Thomson, MD, LLC doing business as Hamilton Mill Pediatrics.

I have also been given the opportunity to receive my own personal copy of the Notice of Privacy Practices.

I understand that the Notice of Privacy Practices, details how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _________________________ Date: __________

Relationship (if not signed by patient): _________________

Authorized Chaperones

Today's Date: ____________________

I, _______________________________________ , the natural parent/guardian of

____________________________________, give the following people of legal age (18+) listed below, to bring my child to Hamilton Mill Pediatrics for medical care and treatment. This statement will remain in effect until I give written notice of any changes.

Thank you,

____

People authorized to bring in child:

____

____

____

____

____

____

____

____

____

____

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Patient Eligibility Screening Record - Vaccines for Children Program

Today's Date: ____________________

This provider practices in the Vaccine for Children Program (VFC). If you meet the requirements of this program, we can provide you child's immunizations at a reduced fee. In order to determine eligibility, we must know if your child has insurance that pays for immunizations.

Child: ____ Date of Birth: ____________
Last Name, First Name MI (MM/DD/YY)

Parent/ Guardian: ____
Last Name, First Name MI

<u>Ineligible for State-Supplied Vaccines (Check if applicable)</u>
☐ The child has insurance that pays for immunizations (fully-insured/Private Pay)

<u>Eligible for State-Supplied Vaccines</u>
☐ The child is enrolled in Medicaid
☐ The child is enrolled in PeachCare for kids
☐ The child is American Indian or Alaskan Native
☐ The child does not have health insurance (not insured)
☐ The child has health insurance that does not pay for vaccines (underinsured)

A record must be kept in the healthcare providers office that reflects the status of all children 18 years of age or younger, who receives immunizations through vaccines supplied by state programs. The record may be completed by parent, guardian, an individual record, or by 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 similar record for each child receiving vaccines.

Screening Updates

Date Screened	PeachCare for kids	Medicaid	Uninsured	Under-insured	American Indian or Alaskan Native	Not Eligible

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY DATE COMPLETED

BIRTH DATE AGE M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. ____________

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

____

Birth History ☐ Don't know birth history

Birth weight ________ Was the baby born at term? ________ OR ________ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain ____________

Was a NICU stay required? ☐ Yes ☐ No Explain ____________

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What ____________ When ____________

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? ________

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain ____________

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain ____________

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain ____________

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain ____________

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain ____________

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain ____________

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain ____________

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Nasal allergies ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Asthma ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Tuberculosis ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Heart disease (before 55 years old) ☐ Yes ☐ No ☐ DK Who ________ Comments ________

High cholesterol/takes cholesterol medication ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Anemia ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Bleeding disorder ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Dental decay ☐ Yes ☐ No ☐ DK Who ________ Comments ________

Cancer (before 55 years old) ☐ Yes ☐ No ☐ DK Who ________ Comments ________

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Condition	Yes	No	DK	Who	Comments
Liver disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Obesity	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Developmental disability	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tobacco use	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

Additional family history ______

Past History DK = don't know

Does your child have, or has your child ever had,

Condition	Yes	No	DK	When/Explain
Chickenpox	☐ Yes	☐ No	☐ DK	When ______
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain ______
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain ______
HIV	☐ Yes	☐ No	☐ DK	Explain ______
Organ transplant	☐ Yes	☐ No	☐ DK	Explain ______
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain ______
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain ______
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain ______
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain ______
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain ______
Cancer	☐ Yes	☐ No	☐ DK	Explain ______
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain ______
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain ______
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain ______
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain ______
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain ______
Obesity	☐ Yes	☐ No	☐ DK	Explain ______
Diabetes	☐ Yes	☐ No	☐ DK	Explain ______
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain ______
High blood pressure	☐ Yes	☐ No	☐ DK	Explain ______
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain ______
Tobacco use	☐ Yes	☐ No	☐ DK	Explain ______
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain ______
Developmental delay	☐ Yes	☐ No	☐ DK	Explain ______
Dental decay	☐ Yes	☐ No	☐ DK	Explain ______
History of family violence	☐ Yes	☐ No	☐ DK	Explain ______
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain ______
Pregnancy	☐ Yes	☐ No	☐ DK	Explain ______
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain ______

Has had first period ☐ Yes ☐ No Age of first period ______

Any other significant problem ______

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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TB/Lead Risk Assessment Questionnaire

Patient Name: ____ **Date of Birth:** ________________

These assessments will be used at all well child checkups. Start at the top by providing the date you are seen, next answer yes (Y) or no (N) in the first column available, and then initial on the line provided below the column. Please do this for each section.

Tuberculosis Risk Assessment

Dates of Service										
Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or an abnormal chest X-ray?										
Has the child been in close contact to a person sick with active TB?										
Was the child born outside the United States or has the child traveled outside the United States?										
Does the child have a household member who was born outside the United States or who has traveled outside the United States?										
Is the child exposed to a person who: is currently in jail or who has been in jail in the past 5 years? has HIV? is homeless? Lives in a group home? Uses illegal drugs? Or is a migrant farm worker?										
Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system?										
Is the child/teen in jail or ever been in jail?										

Initials: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Lead Risk Assessment

Date of Service										
Does your child live in or often visit a house that was built before 1978?										
Does your child live in or often visit a house that is being remodeled or is having paint removed?										
Does your child live with or often visit another child that has an elevated blood lead level?										
Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?										
Does your child chew on or eat non-food items like paint chips or dirt?										
Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?										
Does your child receive medicines such as great, azarcon, kohl, or pay-loo-ah?										

Initials: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____