PAMPA
Patient Registration Form

PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S FAMILY MEDICAL HISTORY.
PLEASE BE ACCURATE, LEGIBLE, AND THOROUGH WHEN FILLING OUT THE INFORMATION

Child 1: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname:** _____

Child 2: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname:** _____

Child 3: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname:** _____

Child 4: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname**: _____

Child 5: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname**: _____

Parent / Guardian 1: Last Name: _____ First Name: _____ MI: _____

Relation to Patient: Biological Mother / Biological Father / Adoptive Mother / Adoptive Father / Step-Parent / Other *(Please Specify)*:_____

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Date of Birth:** _____ / _____ / _____

Mailing Address: _____
(Street or PO Box) (City) (State & Zip)

Can contact have access to patients records? YES / NO **Primarily resides with patient?** YES / NO / 50%

*__Email:__ _____@_____ **Employer:** _____

Circle One
*__Primary Phone__ (*Cell / Home):(_____) _____ - _____ Other Phone: (_____) _____ - _____

*__PAMPA__ *may send information regarding appointment reminders, prescription recalls, billing statements as well as general notices via email and/or text message. If you wish to opt out of these services* ***Initial Here*** _____

Parent / Guardian 2: Last Name: _____ First Name: _____ MI: _____

Relation to Patient: Biological Mother / Biological Father / Adoptive Mother / Adoptive Father / Step-Parent / Other *(Please Specify)*:_____

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Date of Birth:** _____ / _____ / _____

Mailing Address: _____
(If different than above) (Street or PO Box) (City) (State & Zip)

Can contact have access to patients records? YES / NO **Contact primarily resides with patient?** YES / NO / 50%

*__Email:__ _____@_____ **Employer:** _____

Circle One
*__Primary Phone__ (*Cell / Home):(_____) _____ - _____ Other Phone: (_____) _____ - _____

*__PAMPA__ *may send information regarding appointment reminders, prescription recalls, billing statements as well as general notices via email and/or text message. If you wish to opt out of these services* ***Initial Here*** _____

How did you originally hear about our practice?

(Friend/Neighbor) (Doctor) (Insurance) (Internet) (Other) _____

Insurance information:

Primary Policy: Insurance Carrier: _____ ID#: _____

Policy Holder: Name: _____ Birth Date: _____ /_____ /_____ Sex: M / F

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

Is there a court order that restricts either parent from obtaining information related to the child(ren)'s medical handling and/or consenting to medical treatment on behalf of the patient(s)? ***Yes / No***

If yes, please briefly explain below and provide the supporting documents so they can be kept on file.
(It will be assumed both parents have "joint legal custody" unless there is an authorized document stating otherwise)

Emergency Contact, ******Other Than Parent(s)***:***

Name: _____ Relationship to Patient: _____ Phone:(_____) _____-_____

If necessary can this contact can have access to patients records and information? **YES / NO**

Financial/Privacy Policies (HIPAA)

(Initial) _____ I authorize PAMPA to treat the above-named child (children) and to release medical and billing information to the insurance company so that payment for charges can be processed.

(Initial) _____ I understand that for PAMPA to file my insurance, I must present a valid card at the time of each visit. If no proof of insurance is provided I must pay for the services rendered at the time of service.

(Initial) _____ I authorize my children to receive health services with the understanding that if our insurance or managed care company determines that any services provided are non-covered services, I will be billed and held responsible for services rendered. Co-pays, deductibles and co-insurance amounts are due at time of service. A billing fee of $15 a month will be applied to any balance not paid at time of service. ***(Initial)*** _____ I acknowledge the Administrative Fee (ASF) is a yearly fee intended to cover the cost of certain administrative services we may provide which are not covered by your insurance.

(Initial) _____ I acknowledge the cancellation policy which states that PAMPA requires a 24-hour cancellation notice for all well child checkup visits and consultations. A $25.00 fee will be assessed per child for any missed or cancelled appointments without appropriate notice. Your cancellation must be made during regular office hours. As always, emergencies and unforeseen circumstances are taken into consideration.

Authorized Signature: _____ *Date* _____

Printed Name: _____Relationship to child(ren) _____

PATIENT HISTORY

Name _____ Male ☐ Female ☐
First *Middle* *Last*

Name child is called by _____ Birthdate _____ Race _____

Where was the child born? _____ Obstetrician _____

Is child adopted? _____ At what age? _____ Is child aware? _____

Full term pregnancy? _____ Premature? _____ Type of delivery? _____

Mother: Have you had breast surgery? _____

Did you take hormones or medicines during pregnancy? _____

Were there any abnormal ultrasound findings in pregnancy? _____

Complications in pregnancy or problems at birth? _____

Birth wt. _____ Length _____

PATIENT'S PAST MEDICAL/SOCIAL HISTORY

Any concerns for learning or development? _____

Any concerns for growth? _____

Concern for numerous: Ear Infections _____ Strep throats _____

Pneumonia _____

Convulsions/Seizures _____

Urinary Infections _____ Bed Wetting/Soiling problem? _____

Asthma or any use of inhaler/nebulizer? _____

Allergic to any medication? _____

Allergic to any food or insects? _____

Any smokers at home? _____ Any pets? _____

Is he/she receiving allergy shots? _____

Heart Disease? _____ A heart murmur? _____

Meningitis? _____

Has child received blood transfusion or blood products? _____

Any orthopedic (bone, joint, muscle) problems? _____

School problems/performance:

Scholastic _____ Conduct _____

Has child had a learning problem? _____

Has child ever been in a special class? _____

Any other past illness? _____

OPERATIONS (Enter Dates)

Circumcision _____

Tonsils and Adenoids _____

Appendectomy _____

Ear Tubes _____

Other operation or hospitalizations _____

_____

_____

FAMILY HISTORY

PARENT	BIRTH DATE	HT.	WT.	MEDICAL PROBLEMS	EDUCATIONAL LEVEL

Any history in close relative (parent, sibling, aunt, uncle, grandparent) of: (please check appropriate items)

__ Allergies
__ Asthma
__ Birth Defects
__ Bleeding Disorders
__ Blood Clots
__ Clotting Disorders
__ Cancer
__ Chemotherapy
__ Congenital Heart Defects
__ Diabetes
__ Genetic Disorders
__ Heart Disease
__ Heart Attack before age 55
__ High Blood Pressure
__ High Cholesterol
__ Kidney Disease
__ Liver Disease
__ Mental Health Disorders
__ Polycystic Ovarian Syndrome
__ Seizures/Epilepsy
__ Substance Abuse
__ Sudden Unexpected Death
__ Thyroid Disease
__ Tuberculosis

Who is legal guardian? _____ With whom does child live? _____

Has there been a separation, divorce or death? _____ When? _____

Remarriage? _____ Attitude of your child to the situation? _____

This Section for M.D. only

Date reviewed: _____

By: _____

PAMPA VACCINE STATEMENT

Protecting your children, our children and the community by giving the currently available vaccines is one of the most important medical interventions we provide to children. The risks of the diseases are far greater than the risks of the vaccines themselves. Therefore, we encourage all parents to ensure their children's health by immunizing them on time.

Immunizations are safe. The recommended vaccines and the recommended schedule are the results of over a century of research. Vaccine safety is confirmed by the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC).

The CDC and American Academy of Pediatrics (AAP) recommended vaccine schedule gives vaccines when they are most effective. Multiple vaccine doses over time are necessary to provide the best protection against disease. Delaying vaccines puts children and the community at unnecessary risk. Giving the vaccines on the recommended schedule ensures that children have immunity when they are most susceptible to preventable diseases.

Parents are faced with an overwhelming amount of information about vaccines and their possible side effects. We encourage them to look for sources not based on the anecdote and emotion but sources based on scientific evidence, such as the internet sites listed below.

www.immunize.org (Immunization Action Coalition)

www.cdc.gov/vaccines (CDC website)

Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us. You will have the opportunity to discuss any questions you have about vaccinations with your provider at all future visits.

The Providers of PAMPA

I have read and understand the above PAMPA vaccine statement. I understand that if I refuse recommended vaccines, or fail to keep my child (children) up to date with the AAP/CDC recommended schedule, that I may be asked to seek pediatric medical care elsewhere.

Parent's Name: _____

Parent's Signature: _____

Date: _____

PEDIATRICS AND ADOLESCENT MEDICINE, P.A.

WILSON P. ANDREWS JR., M.D., F.A.A.P
DONNA W. FEARING, M.D., F.A.A.P
STEPHANIE HASSEL McNEIL, M.D., F.A.A.P
BAKARI Z. MORGAN, M.D., F.A.A.P
JULIA M. WORLY, M.D., F.A.A.P
NEELIMA TURLAPATY, M.D., F.A.A.P
TAMARA NIX, M.D., F.A.A.P

NICOLE SMAIL, M.D., F.A.A.P
RICHARD BIEN, M.D., F.A.A.P
DINA ROYAL, M.D., F.A.A.P
DEBRA P. FLEMING, M.D., F.A.A.P
ANNA C. SCHULENBORG, M.D., F.A.A.P
CHRISTINE CHERNIK, A.P.R.N., C.P.N.P
DEBBIE KING, A.P.R.N., C.P.N.P
KELLY SIERRA, A.P.R.N., C.P.N.P.

Steps to add your newborn to your insurance plan

It is very important to add your newborn to your insurance policy. Please contact your insurance by phone to update them on the birth of your baby. This usually takes care of coverage for the first 31 days to allow time for the baby to be added to the plan.

You must then contact you Human Resource Department to enroll the baby for coverage. They can expedite the necessary paperwork to the insurance carrier to assure that there is continuous coverage. If this is not done, your newborn's coverage could be terminated pending the receipt of this paperwork. Your insurance may then require that you wait until open enrollment with your company before they will add the baby to your policy. This means that your baby will be uninsured. Please be advised that if you do not submit the necessary paperwork to your insurance company within 31 days, any pending charges will become your responsibility. If you have any questions regarding these steps, please contact a Patient Account Representative in your primary office who will be happy to assist you.

Thank you in advance for your cooperation,

P.A.M.P.A

2155 POST OAK TRITT RD.
SUITE 100
MARIETTA, GA 30062
TELEPHONE 770-973-4700

11755 POINTE PLACE
SUITE C
ROSWELL, GA 30076
TELEPHONE 770-740-0601

100 STONE FOREST DRIVE
SUITE 300
WOODSTOCK, GA 30189
TELEPHONE 770-517-6804

755 MT. VERNON HWY., N.E.
SUITE 420
ATLANTA, GA 30328
TELEPHONE 404-255-6335