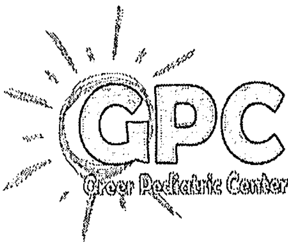


Patient Information Form

Patient Information

Child's Name ________________________________ ☐ Male ☐ Female
(First) (Middle) (Last)

Name preferred ____________________ Child's DOB ____________________

Child's Street Address ____

Child's Mailing Address ____

City ______________ State ________ Zip ________ Home # ______________

Ethnic group (please select one): ☐ Hispanic/Latino ☐ Non Hispanic/Latino

Race (please select one or more of the following racial categories):

☐ American Indian or Alaska Native ☐ Asian ☐ African American

☐ Native Hawaiian or Pacific Islander ☐ Caucasian ☐ Other

Preferred Language: ____________________

With whom does child live with?	☐ Mom and Dad	☐Mom	☐Dad	☐Other
Who has legal custody?	☐ Mom and Dad	☐Mom	☐Dad	☐Other
Who is responsible party?	☐ Mom and Dad	☐Mom	☐Dad	☐Other

List all household members and their relationship to patient:

____

____

Emergency Contact & Relationship (Someone Not in Home)

1. Name ____________________ Phone # ______________
2. Name ____________________ Phone # ______________

Pharmacy Information

Our office prefers to fax medications to the pharmacy. Please list your preferred pharmacy. If you prefer the prescription to be hand written so that you can take it to the pharmacy of your choice, please inform our staff.

Preferred Pharmacy ______________________________

Mother/Guardian Information

Name ______________________ Maiden Name ______________________

Address (if different than patient's) ______________________

Phone # __________ ____ Cell # __________ Work #__________

Employer __________ Employer Address ______________________

DOB __________ SS # __________ **Email** __________

Relationship to patient ______________________

Father/Guardian Information

Name ______________________

Address (if different than patient's) ______________________

Phone # __________ ____ Cell # __________ Work #__________

Employer __________ Employer Address ______________________

DOB __________ SS # __________

Relationship to patient ______________________

Child's previous pediatrician

Name ______________________ Phone # __________

Insurance Information (Please give card to receptionist)

Insurance Company name ______________ Co-pay amount $ __________

Policy/ID ______________ Group # __________

Policy holder's full name ______________ DOB__________

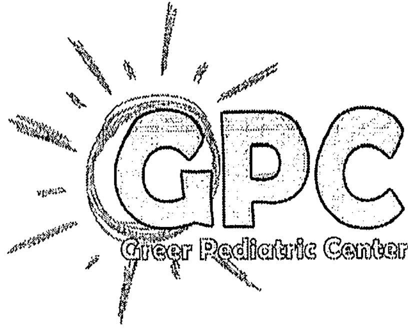
Policy holder's relationship to patient: __________ Effective date __________

I understand that payment of all medical care is ***due at the time of service***. In case of divorced parents, responsibility and payment shall be ***that of the guardian bringing the child in for treatment***. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my Insurance authorizes and to inform the staff of Greer Pediatric Center, LLC. as to which laboratory my insurance covers.

I hereby grant permission to Greer Pediatric Center, LLC to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Greer Pediatric Center, LLC. A photo static copy of this authorization shall be considered as effective and valid as the original

Signature: ______________________ Date: ________



RELEASE OF MEDICAL RECORDS

I request that: ____
(Physician)

____
(Practice)

____
(Address)

____

____

______________________ ______________________
(Telephone) (Fax)

Please release the complete medical records including progress notes, nurse notes, labs/x-rays reports, hospital records, immunizations and any referral/consult notes on the following patient(s) from their birth to present:

Child's Full Name: ______________________________ DOB: ____________

Please send the records to:

Greer Pediatric Center, LLC
111 Memorial Drive
Greer, SC 29650
Phone (864) 848-7005 Fax (864) 848-3666

I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited.

- I understand that this form does NOT authorize the release of any medical information concerning HIV test results and/or treatments, sexually transmitted diseases, generic testing, psychiatric care, psychological assessment and/or treatment, drug or alcohol abuse testing and/or treatment or pregnancy treatment. Consent to release this information requires a separate form and signature.
- I understand that I may revoke this consent at any time except to the extent that this action has already been taken and that it expires 90 days from the date indicated below.

Parent/Guardian: ________________________________ Date: __________
Relationship to Patient: ____________________________ (Patient must sign if 18 years or older)

Pregnancy history with this child

Have you had breast surgery? □ Yes □ No
Did you take hormones during pregnancy? □ Yes □ No
Did you take any drugs during pregnancy? □ Yes □ No
Did you smoke during pregnancy? □ Yes □ No
Did you drink any alcoholic beverages during pregnancy? □ Yes □ No
Has the child's mother had any miscarriages, still births, or abortions? □ Yes □ No
If yes, please list ______________________________
Was the child the product of artificial insemination or donor egg? □ Yes □ No
Did mother see a perinatologist during pregnancy? □ Yes □ No
If mother did see a perinatologist, was there an abnormal ultrasound? □ Yes □ No

Birth history of child

Where was your child born? ______________________ □ Full term □ Pre term at ____ weeks
Was the baby adopted? □ Yes □ No If yes, at what age? ____
Type of delivery: □ vaginal □ C-section Birth weight _____ lb ____oz Birth length ______ in
Were there any birth complications? (If so, please explain) ______________________________

____

____

____

____

Is the baby breast fed or bottle fed? (If bottle fed, what formula?) ______________________________

Family history

	DOB	HT.	Alive/Deceased	Medical Problems
Mother				
Father				

Is there a family history of any of the following? (Include mother, father, siblings, grandparents, aunts and uncles)

Please check all that apply:

Diabetes □
Asthma/Wheezing □
Vision or hearing □
Thyroid Disease □
Mental Problems □
Emotional Problems □
Hyperactivity or learning disabilities □

Bleeding Tendencies □
High Cholesterol □
High Blood Pressure □
Early Heart Attacks □
Other Heart Disease □
Hip Disorders in Birth □

Birth Defects □
Cancer □
Seizures□
Kidney Disease □
Migraines □
Other Illnesses □

If answered yes to any of the above, please explain ______________________________

____

____

____

____

____

Social History

Marital status of parents: □Married to each other □Married to others □Single
Has there been a separation, divorce or death? Specify: ____________________
What has been the attitude of your child to this situation? ____________________
Will the child attend daycare? □ Yes □ No
Is there a gun in your home? □ Yes □ No
Are there any pets at home? □ Yes □ No
Does anyone in your home smoke? □ Yes □ No
What type of water do you have at home? □ City □ County □Well
House type: □ House □ Modular home □ Apartment □Other
Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, megavitamins, acupuncture or herbal medicine: □ Yes □No

Child's Development

Please list age of child when the following milestones were reached

Sat alone @ ____mos. Walked @_____mos. Words @ _____ mos. Sentences @ _______ mos.
First teeth @ _____mos. Bladder trained @_______mos. Bowel trained @ ________mos.
Does the child have any handicap? □ Yes □ No Please specify____________________
Is there a bed-wetting problem? □ Yes □ No
Is there a family history of bed-wetting? □ Yes □ No

School performance

Scholastic performance: Academic ____________________
Behavior ____________________
Has child ever been in a special education class? □ Yes □ No
Has the child had a learning problem? □ Yes □ No
If yes, what type of learning problem? ____________________

Past illnesses

Please mark date or frequency of illness or specify substance causing allergy.

Ear infections ____________
Tonsillitis ____________
Pneumonia ____________
Convulsions ____________
Eye Problem ____________
Bronchitis/Wheezing ____________
Chicken Pox ____________
Urinary infections ____________
Heart Murmur ____________
RSV ____________
Has he/she received allergy shots? □ Yes □ No
Other ____________________
Allergic to Medication ____________
Allergic to Foods ____________
Allergic to Insect Bites ____________
Asthma ____________

Medications

Is your child taking any medication on a regular basis? □ Yes □ No
Please specify ____________________

Surgeries and Hospitalizations

Please specify date or reason.

Appendectomy__________ Tonsils and Adenoids ____________ Ear tubes ______

Other operations ____

List all past hospitalizations, reason for hospitalization and dates ____________________

____

____

____

Review of Symptoms

(Please check all that apply)

Constitutional

__Fever/chills/excessive Sweating

__Unexplained weight loss

Eyes

__Squinting/crossed eyes/ Crooked gaze

Ears/Nose/Throat

__Unusually loud voice/ Hard of hearing

__Mouth breathing/snoring

__Bad Breath

__Frequent runny nose

__Problem with teeth/gums

Blood/Lymph

__Unexplained lumps

__Easy bruising/bleeding

Cardiovascular

__Tires easily with exertion

__Shortness of Breath

__Fainting

Respiratory

__Cough/wheeze

__Chest Pain

Gastrointestinal

__Nausea/vomiting/diarrhea

__Constipation

__Blood in bowel movements

Genitourinary

__Bedwetting

__Pain with urination

__Discharge, penis or vagina

Musculoskeletal

__Muscle/joint pain

Skin

__Rashes

__Unusual Moles

Allergy

__Hay fever/itchy eyes

Neurological

__Headaches

__Weakness

__Clumsiness

Psychiatric/Emotional

__Speech Problems

__Anxiety/stress

__Problems with sleeping

__Nail biting/thumb sucking

__Bad temper/breath holding

Sibling Information

Name ____________________ DOB __________ Name ____________________ DOB __________

Name ____________________ DOB __________ Name ____________________ DOB __________

Name ____________________ DOB __________ Name ____________________ DOB __________

Name ____________________ DOB __________ Name ____________________ DOB __________

How did you hear about us, or who referred you to us? ____________________________

Name of person completing this form ____________________ Date ______

MD/PNP Reviewed: ____________________________ Date ______

Permission for Telephone Messages

Patient confidentiality is a top priority at Greer Pediatric Center. Therefore, it is important that parents or patients over 18 years of age provide us with the following information to ensure there is no violation of your or your child's privacy.

Please name all persons and places where we may leave health information including return phone messages, lab and test results, and scheduling:

Name: (Mother) ______________________
Email address: ______________________
Home phone #:______________________
Cell phone #:______________________
Work phone #:______________________

Name: ______________________
Email Address: ______________________
Home Phone #: ______________________
Cell Phone#: ______________________
Work Phone#: ______________________

Name: (Father) ______________________
Email Address: ______________________
Home phone #:______________________
Cell phone #:______________________
Work phone #:______________________

Name: ______________________
Email Address: ______________________
Home Phone#: ______________________
Cell Phone#: ______________________
Work Phone#: ______________________

I understand that if the status of any of above information changes, it will be my responsibility to inform the staff of Greer Pediatric Center, LLC..

Parent signature: ______________________________ Date: ____________

Treatment Authorization

I (We) ______________________________authorize Greer Pediatrics and its personnel to deliver
Print Name of Legal Guardian(s)

medical services to my child, ______________________.
Child's Name and Date of Birth

I (We) authorize the following people to bring my child in for treatment:

Name: ________________________ Relationship: __________

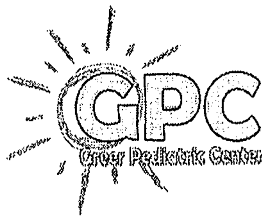
Name: ________________________ Relationship: __________

Name: ________________________ Relationship: __________

Name: ________________________ Relationship: __________

Name: ________________________ Relationship: __________

Name: ________________________ Relationship: __________



111 Memorial Drive
Greer, SC 29650

NEW OFFICE POLICIES
EFFECTIVE JULY 1, 2023

No Show Appointment Policy- In consideration of other patients, we ask you to notify our office at least 24 hours in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient, who needs to see the doctor. **THREE** consecutive missed appointments will result in dismissal from the practice.

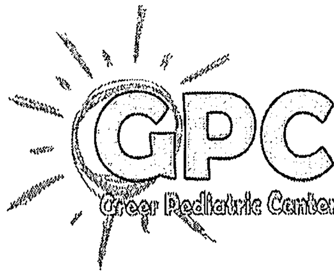
Late Policy- When you are more than 30 minutes late for your child's appointment, our front office staff will ask your doctor to help determine when best to see your child. You may be worked into the schedule with a wait, or you may be asked to reschedule, especially if it is a well-child visit. We are always trying our best to balance your needs with the needs of our other patients.

Transfer Policy- When a parent/guardian (also known as guarantor) transfers one child to another practice, then all children associated to that parent/guardian are made inactive and in effect transferred. A letter will be sent to the parent/guardian confirming transfer of medical records and notice of all children being made inactive. Greer Pediatric Center will release all medical records to the new provider once the signed release request (must have request on all children) has been received from the new provider. **Once the confirmation letter has been sent, we will see the child and associated children on an emergency basis for 30 days.**

Please remember we are always looking for ways to improve our practice and provide high-quality healthcare to your children.

I, ______________________________, have read and understand the policies above.

Signature ______________________________ Date __________________



FINANCIAL AGREEMENT

Patient Name ______________________________ DOB ______________________

As a member of ___________________________________ insurance plan, I am aware of the responsibility that certain services rendered to my child/children by my physician may be considered non-covered or deemed not necessary by my insurance plan.

If my insurance denies payment to Greer Pediatric Center, LLC, because the services rendered to the patient are considered non-covered or deemed not medically necessary, I agree to be personally and fully responsible for payment of these services.

I understand that I am responsible for all co-pays, deductibles and coinsurance amounts that are made my responsibility by the insurance company. *I understand that if my co-pay is not paid at the time of service, that there will be a $25 processing fee due in addition to the visit co-pay.*

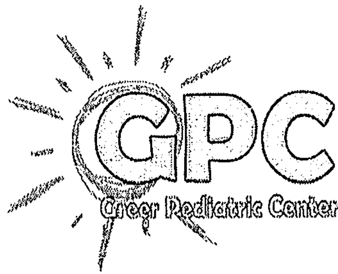
I understand that failure to pay any patient balance due from me will result in the account being turned to an outside collection agency and a fee of **35%** of the balance will be assessed on the account, in addition to the balance owed. I also understand that I will be responsible for all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on my account.

____

Parent/Guardian Printed Name

____

Parent/Guardian Signature Date



RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the Greer Pediatric Center Privacy Officer at **864-848-7005**; by submitting a written request to **111 Memorial Drive, Greer, SC 29650** or from any of our office locations.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name ____

Signature of Patient/Personal Representative ____________________________

Date ____________________