Athens Pediatrics PLLC
Patient Registration

Child 1-Last Name: ____________________ **First Name:** ____________________ **MI:** ________

D.O.B.: ___/___/____ Sex: ___ SS#____________ Primary Language: ____________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian /Black/Hawaiian/White

Child 2-Last Name: ____________________ **First Name:** ____________________ **MI:** ________

D.O.B.: ___/___/____ Sex: ___ SS#____________ Primary Language: ____________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian /Black/Hawaiian/White

Child 3-Last Name: ____________________ **First Name:** ____________________ **MI:** ________

D.O.B.: ___/___/____ Sex: ___ SS#____________ Primary Language: ____________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian /Black/Hawaiian/White

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

Primary Home Phone: (___) ____-_____ Primary Contact E-Mail________________________

Who lives in the household? ____

Mother or Female Guardian Name: ____

Address: ____

Date of Birth: ___/___/____ SS#:________________ Employer: ____________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Father or Male Guardian Name: ____

Address: ____

Date of Birth: ___/___/____ SS#:________________ Employer: ____________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Guardians please provide the front office with the custody paper. Do the parents have privileges? Y / N

Mother's Name: ______________________ Father's Name: ______________________

Insurance:

Primary Insurance:

Insurance Carrier: ____________________ ID# ____________________ Group# ______________

Policy Holder's Name: ____________________ DOB: ____________ Sex: M/F Relationship________

Secondary Insurance:

Insurance Carrier: ____________________ ID# ____________________ Group# ______________

Policy Holder's Name: ____________________ DOB: ____________ Sex: M/F Relationship________

OVER➔

Please bring the insurance cards with you at each visit.

If your child has TennCare and any other kind of insurance, we must file the other insurance first. Failure to provide this information could lead to you being responsible for the charges.

Co-pays are due at the time of service and are the responsibility of the person bringing the child in for the visit.

If parents are divorced or separated please fill out this section:
Who has custody? ________________________________

Who should receive the billing statement? ____________________

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child/children or from obtaining information about the child's medical treatment? Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction? ________

____

Emergency Contacts, other than parents: Name & Relationship

Do these contacts have permission to bring child/children in for medical treatment?

1. ____ Phone: (____) _____-_____ Yes / No
2. ____ Phone: (____) _____-_____ Yes / No
3. ____ Phone: (____) _____-_____ Yes / No
4. ____ Phone: (____) _____-_____ Yes / No

I give all providers and staff at Athens Pediatrics PLLC, permission to diagnose and treat my child/children.

I have read Athens Pediatrics PLLC financial policy and understand that I am responsible for any charges incurred at Athens Pediatrics PLLC.

I have received a copy of Athens Pediatrics PLLC HIPAA policy. We are required by law to protect the privacy of your information. If you have any questions, please contact the HIPAA officer or office manager.

Print Name: ____________________ Signature: ____________________ Date: ____________

If you are a new patient, how did you hear about us? (circle one)-

Family/Friend referral   Yellow Pages   Internet search   Billboards   newspaper   Other________

Thank you for choosing Athens Pediatrics, PLLC.

Initial History Questionnaire

FORM COMPLETED BY ______ DATE COMPLETED ______

Name ______

ID NUMBER ______

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 and ages and where they live. ______

If mother and father are not living together or if child does not live with parents, what is the child's custody status? ______

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? ______

Birth History

Birth weight ______

Was the baby born at term? ______ Early? ______ Late? ______

If early, how many weeks' gestation? ______

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain ______

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What ______ When ______

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? ______

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain ______

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ______

General

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

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain ______

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain ______

Has your child had any surgery? ☐ Yes ☐ No Explain ______

Has your child ever been hospitalized? ☐ Yes ☐ No Explain ______

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain ______

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain ______

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain ______

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain ______

If your child is in school:

How is his/her behavior in school? ______

Has he/she failed or repeated a grade in school? ______

How is he/she doing in academic subjects? ______

Is he/she in special or resource classes? ______

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	Who ______	Comments ______
Asthma	☐ Yes	☐ No	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	Who ______	Comments ______
Heart disease (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High cholesterol	☐ Yes	☐ No	Who ______	Comments ______
Anemia	☐ Yes	☐ No	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	Who ______	Comments ______
Liver disease	☐ Yes	☐ No	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	Who ______	Comments ______
Diabetes (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	Who ______	Comments ______
Mental illness	☐ Yes	☐ No	Who ______	Comments ______
Mental retardation	☐ Yes	☐ No	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who ______	Comments ______

Additional family history ______________________________

____

____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When ______
Frequent ear infections	☐ Yes	☐ No	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	Explain ______
Nasal allergies	☐ Yes	☐ No	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	Explain ______
Blood transfusion	☐ Yes	☐ No	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	Explain ______
Bladder or kidney infection	☐ Yes	☐ No	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain ______
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When ______
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain ______
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain ______
Frequent headaches	☐ Yes	☐ No	Explain ______
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain ______
Diabetes	☐ Yes	☐ No	Explain ______
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain ______
Any other significant problem	☐ Yes	☐ No	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	Explain ______

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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