Peachtree Pediatrics
Patient Demographics

PATIENT'S NAME ______________________ D.O.B_____/_____/_____
ADDRESS ______________________
CITY ______________________ STATE________ ZIP CODE__________
FEMALE / MALE (circle one) SSN# ______-______-______

FATHER
FIRST NAME______________________
LAST NAME______________________
D.O.B _____/_____/_____
SSN# ______-______-______
PRIMARY PHONE # ______-______-______
WORK PHONE# ______-______-______
EMAIL______________________
ADDRESS (**if different than child's**)
____
CITY______________________
STATE __________ ZIP CODE __________

MOTHER
FIRST NAME______________________
LAST NAME______________________
D.O.B _____/_____/_____
SSN# ______-______-______
PRIMARY PHONE # ______-______-______
WORK PHONE# ______-______-______
EMAIL______________________
ADDRESS (**if different than child's**)
____
CITY______________________
STATE __________ ZIP CODE __________

SIBLINGS
PATIENT'S NAME ______________________ D.O.B _____/_____/_____ F / M
PATIENT'S NAME ______________________ D.O.B _____/_____/_____ F / M
PATIENT'S NAME ______________________ D.O.B _____/_____/_____ F / M
PATIENT'S NAME ______________________ D.O.B _____/_____/_____ F / M

EMERGENCY CONTACT (if unable to reach parents)
NAME ______________________
PHONE # ______-______-______
RELATIONSHIP TO PATIENT ______________________

PHARMACY INFO
PHARMACY NAME OF CHOICE ______________________
LOCATION ______________________
PHONE # ______-______-______

INSURANCE INFO
INSURANCE NAME ______________________
MEMBER ID# ______________________
MEDICAID# (if applicable) ______________________
GROUP #(if applicable) ______________________
SUBSCRIBER'S NAME ______________________
D.O.B _____/_____/_____ SSN# ______-______-______
RELATIONSHIP TO PATIENT ______________________

FINANCIAL RESPONSIBILITY
LAST NAME ______________________
FIRST NAME ______________________
D.O.B ______________ SSN# ______________
ADDRESS (**if different than child's**)
____
____
PH # ______-______-______

- I consent to treatment necessary for the care of the above named patient by Peachtree Pediatrics.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I allow fax transmissible of my medical records, if necessary.
- I understand that payment incurred is due at the time of services unless other definite financial arrangements have been made prior to treatment.
- I further authorize and request that insurance payments be made directly to Peachtree Pediatrics should they elect to receive such payments.
- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

PRINT NAME ______________________ **SIGNATURE** ______________________ **DATE** _____/_____/_____

For office use only: Initials__________ Date __________

NAME: ______________________ RTH DATE: __/__/__ DATE FIRST SEEN __/__

RACE: ________ SEX: ______ REFERREL : ______________________

FATHER'S NAME: ______________________ MOTHER'S NAME: ______________________

HOSPITAL: ______________________ OBSTETRICIAN: ______________________

______________________ ADDRESS: ______________________

______________________ PHONE: ______________________

FAMILY HISTORY:

	AGE	HEALTH	ALLERGIES
MOTHER:			
FATHER:			
SIBLING:			
SIBLING:			
SIBLING:			
SIBLING:			

MOTHER'S BLOOD TYPE ________

RH ____

BABY'S BLOOD TYPE ________

MISCARRIAGE: ____________ MONTH ________ CAUSE ____________

TUBERCULOSIS ____________ TBC CONTACT ________ ALLERGY ________

DIABETES ______________________ CONVULSIVE DISEASE ____________

BIRTH AND DEVELOPMENT:

TERM ____ DELIVERY ______ BIRTH WEIGHT ________ APGAR SCORE ________

CONDITION AT BIRTH ____________________ CONDITION FIRST WEEK ________

FEEDING ______ CYANOSIS ______ CONVULSIONS ________ JAUNDICE ________

SAT UP ____ STOOD ______ WALKED ______ WORDS ______ SHORT SENTENCES ______

FIRST TOOTH ______ BLADDER ________ BOWEL ________

FEEDING HISTORY:

BREAST ________ FORMULA ________________ VITAMINS ____________

PRIMARY DRINKING SUPPLY: WELL ___ CITY ____ BOTTLED ______

AREA WATER LEVEL _____ INADEQUATE ________ ADEQUATE ______ UNKNOWN

FLUORIDE SUPPLEMENT: _____ TOPICAL _____ RINSE ____ GEL _____ PASTE

SYSTEMIC ____ VITAMIN/FLUORIDE SUPPLEMENT _____ FLUORIDE - ONLY SUPPLEMENT

SOFT FOODS ________ PRESENT DIET __________ FEEDING HABITS ________

APPETITE ________ LIKES ________________ DISLIKES ____________

VOMITTING ________ STOOLS ________ SENSITIVITY ________ HIVES ________

SIGNIFICANT ILLNESSES:

OTITIS MEDIA ________ ASTHMA (REACTIVE AIR WAY DISEASE) ________

CHICKEN POX ________ PHEUMONIA ________ DIABETES ________

HEART DISEASE ________ OTHER ____________________

HOSPITALIZATIONS:

DATES: ________ DIAGNOSIS ______________________

________ DIAGNOSIS ______________________

________ DIAGNOSIS ______________________

ALLERGIES: ______________________

FOOD: ______________________

MEDICINE:

Peachtree Pediatrics
ANN E. EGGERT, M.D.

12 Eastbrook Bend
Peachtree City, GA 30269
770-487-3330 – Fax 770-487-7736

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I, ________________________________, (please print your name) have received a copy of PEACHTREE PEDIATRICS'S Notice of Privacy Practices, for my child,

________________________________,(please print your child's name.)

WITH THIS CONSENT, PEACHTREE PEDIATRICS, P.C. MAY CALL MY HOME AND LEAVE A MESSAGE ON VOICE MAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENTS REMINDERS, INSURANCE ITEMS AND ANY CALLS PERTAINING TO MY CLINICAL CARE, LABORTATORY RESULTS, PRESCRIPTIONS, MEDICATIONS, AMONG OTHERS.

________________________________ ____________________

Signature of Patient/Parent or Guardian **Date**

HIPPA P/O

6/2003

INSURANCE AND BILLING POLICIES

IT IS IMPORTANT THAT WE CLARIFY OUR POLICIES SO THAT ALL OF OUR PATIENTS WILL UNDERSTAND OUR FILING PROCEDURES.

OUR OFFICE POLICY REQUIRES YOUR CHILD'S INSURANCE CARD TO BE PRESENTED AT EVERY OFFICE VISIT.

EFFECTIVE APRIL 1, 2003 WE ARE REQUIRED TO FILE ALL INSURANCE CLAIMS ELECTRONICALLY TO YOUR INSURANCE CARRIER.

WE ARE NOT RESPONSIBLE FOR KNOWING EACH PATIENTS INDIVIDUAL PLAN BENEFITS. IT IS EVERY PATIENTS RESPONSIBILITY TO BE KNOWLEDGABLE ABOUT THEIR OWN PLAN THROUGH THE INFORMATION PROVIDED BY THEIR EMPLOYER OR INSURANCE COMPANY. WE URGE ALL OUR PATIENTS TO PLEASE **CALL AND *DISCUSS THEIR WELL BENEFITS, IN OFFICE LAB TESTS THAT MAY NOT BE COVERED, SICK VISITS, ETC.***

IF CHARGES APPLY TO YOUR DEDUCTIBLE, WE ASK THAT YOU PAY CHARGES AT THE TIME OF YOUR VISIT. SOME INSURANCE COMPANIES APPLY IN OFFICE TESTS TO DEDUCTIBLE.

PRESENTING AN INSURANCE CARD DOES NOT GUARANTEE YOU FULL COVERAGE ON ALL SERVICES.

PLEASE UNDERSTAND THAT DUE TO OUR PATIENT LOAD AND THE COMPLEX NATURE OF INSURANCE, WE HAVE NEITHER THE STAFF NOR THE RESOURCES NEEDED TO PURSUE ALL OUR PATIENTS INSURANCE PROBLEMS.

WE WILL CHARGE YOUR CO-PAY ON WELL BABY/WELL CHILD PHYSICALS THAT ARE NOT CANCELLED IN ADVANCE.

THERE IS A MINIUM CHARGE OF $24.86 TO RECEIVE COPIES OF YOUR CHILD'S MEDICAL RECORDS. **WE DO NOT FAX MEDICAL RECORDS.**

IF FOR SOME REASON YOU LEAVE OUR PRACTICE, PLEASE BE SURE TO REQUEST A COPY OF YOUR CHILDRENS RECORDS. IF YOUR CHILD'S ACCOUNT IS CLOSED OUT OF OUR ACCOUNTING SYSTEM, MEDICAL RECORDS WILL REMAIN ON SITE FOR A PERIOD OF 3 YEARS. AFTER THAT TIME, RECORDS WILL BE RELOCATED TO STORAGE OFF SITE. IF YOU REQUEST RECORDS THAT ARE OFF SITE, WE WILL CHARGE AN ADDITIONAL $10.00 FOR OFF SITE RETRIEVAL. COPIED RECORDS WILL CONSIST OF GROWTH CHART, PROBLEM LIST, IMMUNIZATIONS, LAST PHYSCIAL OR LAB RESULTS AND ANY SPECIAL REPORTS FROM A SPECIALIST.

Effective July 15, 2006 there will be a $15.00 Annual Administration Fee (1 Time Per Year). This fee is intended to cover completion of forms such as: Day Care & School 3231 Forms. Sports Physical Forms, Camp Forms, College Forms, Memos or Letters requested of the Physician. State Disability Forms, School Attendance Letters, Work Excuses not requested at time of visit.

THERE IS A $30.00 CHARGE FOR ANY RETURNED CHECK FROM YOUR BANK.

WE APPRECIATE YOUR COOPERATION WITH OUR INSURANCE AND BILLING POLICIES. PLEASE SPEAK WITH OUR OFFICE MANAGER IF YOU HAVE ANY SPECIAL ARRANGEMENTS YOU WOULD LIKE CONSIDERED.

SINCERELY,
ANN E. EGGERT, MD.

I HAVE READ AND UNDERSTAND THE ABOVE POLICES:

PATIENT NAME:______________________________

SIGNATURE: ______________________________ DATE: ______________

07/06

Peachtree Pediatrics

ANN E. EGGERT, M.D.

12 EASTBROOK BEND
PEACHTREE CITY, GA 30269
770-487-3330 • Fax 770-487-7736

Welcome to our practice. For further reference please keep this information sheet.

Office Hours: Monday – Friday 8:30 – 12:00 pm
1:00 – 5:00 pm

After Hours: If you need to speak to a physician after hours please contact the office. Your call will be answered by our Answering Service. Depending on the nature of the call a Scottish Rite Pediatric Nurse will assist you or have the On-Call Doctor, call you back as soon as possible. If you do not receive a return call from a physician within 20 minutes please call back. Dr. Eggert will return your call.

If you have a true life or death emergency remember to call 911. Advise your pediatrician later and follow-up with their office for a visit.

We refer our patients to Scottish Rite Children's Hospital in Atlanta and Egleston Children's Hospital also in Atlanta.

Remember to always check with your insurance before choosing Urgent Care or Hospital Facility. Also please obtain referrals if needed by your Insurance. Physicians are not responsible for this follow-up paperwork to your Insurance Company.

In Case of an Emergency Dial: **911**

Poison Control: **404-589-4400/ 1-800-282-5846**

Information you should have available before contacting your child's physician:

1. Your child's main symptoms, (please mention any chronic disease)
2. Your child's temperatures if he or she is sick.
3. Your child's weight.
4. The name and dosage of any medication child is currently taking. Any allergies?
5. The name a pharmacy and their telephone number.

2008

Peachtree Pediatrics

ANN E. EGGERT, M.D.

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PEACHTREE CITY, GA 30269
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AUTHORIZATION FOR RELEASE OF MEDICAL/PSYCHIATRIC/OR DRUG INFORMATION

AUTHORIZATION

PATIENT'S NAME: ______________________________

DATE OF BIRTH: ______________________________

TO: ______________________________

____

____

YOU ARE HEREBY AUTHORIZED TO RELEASE TO:

____

____

____

I, ____________________HEREBY AUTHORIZE THE ABOVE NAMED FACILITY Physician to release my medical record including any psychiatric, or drug abuse information. Specifically, the following (requests for "any and all records" is not accepted):

( ) Laboratory Reports
( ) Pathology Reports
( ) Progress Notes
( ) Psychiatric Notes
( ) History/Physical/Immunizations
( )Operative Reports
( )Radiology Reports
( )Special Diagnostics Reports, i.e. EKG.EEG
( )Discharge Summary
( )Other

USES:
The information is needed for the following purposes (must be checked):

( )Continued care by the receiving facility/physician
( )Claims settlement with insurance company
( )Needed to receive aid by the above agency
( ) Personal Use
( )Other

DURATION:
This authorization is good for a period of 90 days from the date signed.

SIGNATURE

______________________________ ____________
Patient Signature Date

____
Parent/Guardian/Representative Signature