**Please note: Federal Law requires the Parent or Legal Guardian to complete this form one time yearly.**

WELLSTAR® Medical Group

## Wellstar Creekside Pediatrics Registration Form

Child's Legal Name: _____ Nickname: _____
First Middle Last

Date Of Birth: _____ ☐ Male ☐ Female Social Security Number: _____ - _____ - _____

Address: _____
Street Apt # City State Zip Code

Home Tel: (_____)_____ Primary Language Spoken: _____ Ethnicity: _____
Child Lives With: Mom Dad Both Parents Other:_____

Emergency Contact (other than parent): Name: _____
First Last

Relationship to patient: _____ Phone #1:( _____)_____ Phone #2: (_____)_____

***RESPONSIBLE PARTY (PERSON TO RECEIVE BILLS AFTER INSURANCE HAS PAID)*** **Mother____Father____Other _____**

**Mother's Information:**

Name: _____ Date of Birth: _____ Soc. Sec. #: _____ - _____ - _____
First Middle Last

Address: _____
(If Different from above)

Home Tel: (_____)_____ Work Tel: (_____)_____ Cell #: (_____)_____

Employer Name: _____ Telephone #: _____

Address: _____
Street City State Zip

**Father's Information:**

Name: _____ Date of Birth: _____ Soc. Sec. #: _____ - _____ - _____
First Middle Last

Address: _____
(If Different from above)

Home Tel: (_____)_____ Work Tel: (_____)_____ Cell #: (_____)_____

Employer Name: _____ Telephone #: _____

Address: _____
Street City State Zip

**Please complete if child lives with caregiver other than parent:**

Name: _____ Date of Birth: _____ Soc. Sec. #: _____ - _____ - _____
First Middle Last

Address: _____
(If Different from above)

Home Tel: (_____)_____ Work Tel: (_____)_____ Cell #: (_____)_____

Employer Name: _____ Telephone #: (_____)_____

Address: _____
Street City State Zip

**MEDICAL INSURANCE INFORMATION:**

Primary Insurance; _____ _____ _____ _____
Insurance Company Name Policy Holder Name Policy Number Relationship to patient

Secondary Insurance; _____ _____ _____ _____
Insurance Company Name Policy Holder Name Policy Number Relationship to patient

Policy Holder's Address: _____
(If Different from above)

**Signature of Parent or Legal Guardian: _____ Date: _____**

Patient Name: _____ Date of Birth: _____

Assignment of Benefit/ Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payors for service rendered by WellStar and the medical professionals caring for me during my treatment in this office. For healthcare services provided by independent medical professionals (such as radiologists who may read my x-ray films), I understand that I will receive separate bills and that I am responsible for paying them. This assignment will remain in effect until revoked by me in writing; I understand that I am responsible for all charges not paid by insurance.

I authorize WellStar Health System to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this facility and authorize such treatments, examinations, educations, anesthesia, surgical, operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.
By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from
Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care follow-up, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

Signature of Patient/Parent/Legal Guardian: _____

Date: _____

*Acknowledgment Of Receipt*

**"NOTICE OF PRIVACY PRACTICES"**
***for***
***Protected Health Information***

I, acknowledge that I have received a copy of WellStar Health System's
"***Notice of Privacy Practices"*** for Protected Health Information on the date set forth below.

_____
**Date of Receipt**

_____
**Patient Date Of Birth**

_____
**Print Patient Name**

_____
**Print Name of Authorized Personal Representative**

_____
**Signature of Patient**

_____
**Signature of Authorized Personal Representative**

_____
**Please Indicate Relationship to Patient**

**FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY:** ***[Complete if patient Acknowledgment is not obtained]***
***An Acknowledgment of Receipt of Notice of Privacy Practices was not obtained because:***

❒ Patient refused to sign Acknowledgment.
❒ Unable to gain signed Acknowledgment due to communication/language or other barrier.
❒ Patient was unable to sign Acknowledgment due to emergency treatment situation.
❒ Other: *Please indicate reason*_____

Signature of WellStar Representative: _____ Date: _____

***Please check the appropriate facility:***

❒ Kennestone Hospital ❒ Cobb Hospital ❒ Douglas Hospital ❒ Windy Hill Hospital ❒ Paulding Hospital
❒ Homecare ❒ Hospice
❒ Medical Group:_____ ❒ Other: _____

# Important Practice Information: Please read and sign

## NO SHOW

1. If you are unable to keep a scheduled well visit appointment, please cancel the appointment by informing us at least one working day before the appointment date by calling 770-920-2255 during regular office hours.
2. If we see a pattern of no-shows for scheduled well visit appointments without appropriate notice of cancellation, we may be forced to ask you to find a different Practice for your child.

## IMMUNIZATIONS

1. At Creekside Pediatrics we follow the immunization guidelines recommended by the Advisory Committee of Immunization Practice (ACIP) and adopted by the American Academy of Pediatrics (AAP).
2. The ACIP recommendations include the appropriate age for vaccine administration, number of doses and dosing intervals, precautions and contraindications for vaccine administration.
3. We do not recommend any alternate immunization schedule recommended by any other authorities.
4. **If you decline to immunize your child as per ACIP recommendations. We will be unable to continue to provide medical care for your child in our practice.**

## PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Please check one of the following:

☐ I have presented evidence of valid insurance coverage, as of this date below to Wellstar Medical Group

* *Verification of benefits from your Insurance Company is not a guarantee services are covered or will be paid by your insurance company.*

☐ Self-Pay. I have not presented any evidence of insurance coverage. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time services are rendered and I possess the means to render payment today.

Please circle intended method of payment: **CASH** **CHECK** **CREDIT CARD**

In consideration of the services provided at Wellstar Creekside Pediatrics:

- I, the undersigned, hereby assign all hospital and medical provider benefits payable (i.e. "Payor", insurance coverage, Medicare, Medicaid, social security, etc.) and related rights existing under the Payor coverage that I have identified or will identify in connection with the services provided directly to the group and acknowledge this includes my permission to submit all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.
- I understand that any payment received by the Group for this period may be applied to any unpaid bill(s) for which I am liable.
- I understand that different Payor's have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations or that the services be medically necessary.
- I understand that it is my obligation to know my Payor's requirements and ensure that they have been fulfilled.
- I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the Group the full balance that is not reimbursed by medical provider benefits (certain regulations and exceptions apply for Medicare Beneficiaries).
- Additionally, if the Group elects to pursue an appeal of any denials by my Payor of the payment for services rendered, this Statement constitutes written consent that Facility and/or its agents have the authority to pursue any and all appeals, including arbitration, on my behalf. This financial responsibility is hereby affirmed and acknowledged by my signature below.
- I understand that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts, as well as credit reporting to the three major credit bureaus if not paid in a timely manner.
- **I understand that balances sent to outside collection agencies will subject my child/children to being terminated from this practice.**

_____ _____

Parent or Guardian or Patient Date

_____ _____

Print Patient's Name Patient Date of Birth

*NOTE: *If you provided us with insurance information today, you are obligated to pay all co-payments, deductibles and any non-covered out-of-network/reduced benefits at the time services are rendered. You will subsequently be invoiced for any additional amounts, which are not paid by your Insurer. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the Group for reimbursement of services provided. **Please contact the office for more information regarding financial assistance payment plan options that may be available to you*

WELLSTAR Medical Group

Patient Name: _____ Date of Birth: _____

**PEDIATRIC HISTORY FORM**

## BIRTH HISTORY

| | | | |
|---|---|---|---|
| DELIVERY: VAGINAL ☐ CESAREAN ☐ | BIRTH WEIGHT: | PREMATURE? NO ☐ YES ☐ How many weeks? __ | Feeding: Breast ☐ Formula ☐ |

Does this child have any problems with breast or formula feeding? No ☐ Yes ☐ Explain:

Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, feeding problems? No ☐ Yes ☐ Explain:

Did this child need special treatment while in the hospital such as oxygen, transfusions, bili lights? No ☐ Yes ☐ Explain:

## SOCIAL HISTORY

PARENTS: MARRIED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE ☐

SIBLING- Please list: Name/Year of birth:

How many people live in your home? Adults _____ Children _____

Is your child currently enrolled in daycare or school? No ☐ Yes ☐

Does your child participate in regular exercise? No ☐ Yes ☐ Explain:

| | |
|---|---|
| Does your child drink caffeine? No ☐ Yes ☐ | Is there a swimming pool at home? No ☐ Yes ☐ |
| Any smokers at home? No ☐ Yes ☐ | Are there any pets at home? No ☐ Yes ☐ _____ |
| Are there smoke detectors at home? No ☐ Yes ☐ | Carbon Monoxide Detectors? No ☐ Yes ☐ |
| What is your water source? | Are guns kept in your home? No ☐ Yes ☐ |
| Do all family members use seatbelts/car safety seats? No ☐ Yes ☐ | Do All family members use helmets when biking? No ☐ Yes ☐ |

## MEDICAL HISTORY

Hospitalizations? None ☐ Yes ☐ List:

Surgeries? None ☐ Yes ☐ List:

Drug Allergies? No ☐ Yes ☐ List:

**REVIEW OF SYMPTOMS**

| | | |
|---|---|---|
| Any Lung problems? | None | Yes-list: |
| Any Heart problems? | None | Yes-List: |
| Any kidney/urinary problems? | None | Yes-List: |
| Any bone/muscle problems? | None | Yes-List: |
| Any gastro-intestinal problems? | None | Yes-List: |
| Any brain/nervous system problems? | None | Yes-List: |
| Any genital problems? | None | Yes-List: |
| Any skin problems? | None | Yes-List: |
| Any eye/ear/nose/throat problems? | None | Yes-List: |
| Any developmental concerns or learning problems? | None | Yes-List: |
| Any behavioral problems or eating disorders? | None | Yes-List: |

Is your child taking any prescribed or over the counter medications (Include dose and frequeency)?

Are there any medical issues we should be aware of? None ☐ Yes ☐ List:

Provider Initials: _____ Date: _____

WELLSTAR Medical Group

**Patient Name:**_____ **Date of Birth:**_____

## FAMILY MEDICAL HISTORY

| | Child's Father | Child's Mother | Sibling | Sibling | Grandparent | Other |
|---|---|---|---|---|---|---|
| **Year of Birth (if known)** | | | | | | |
| **Year of Death (if known)** | | | | | | |
| **Cause of Death (if known)** | | | | | | |
| **Heart Disease** | | | | | | |
| **High Blood Pressure** | | | | | | |
| **Stroke** | | | | | | |
| **High Cholesterol** | | | | | | |
| **Anemia** | | | | | | |
| **Diabetes (note if onset as Adult or Child)** | | | | | | |
| **Asthma** | | | | | | |
| **Tuberculosis** | | | | | | |
| **Cystic Fibrosis** | | | | | | |
| **Alcohol Abuse** | | | | | | |
| **Drug Abuse** | | | | | | |
| **Mental Problems** | | | | | | |
| **Social Problems** | | | | | | |
| **Psychiatric Problems** | | | | | | |
| **Cancer (type)** | | | | | | |
| **Kidney Disease** | | | | | | |
| **Migraines** | | | | | | |
| **Seizures** | | | | | | |
| **Congenital Birth Defects** | | | | | | |
| **Eating Disorder** | | | | | | |
| **Other:** | | | | | | |
| **Other:** | | | | | | |

## COMMUNICATION NEEDS:

**Language if other than English: Child**_____ **Parent(s)**_____
**Any special communication needs? ☐No ☐Yes**
**If yes, explain:** _____

## PATIENT EDUCATION ASSESSMENT:

**Would you prefer patient education be provided to you or your child by:**

- ☐ **Demonstration**
- ☐ **Written Materials**
- ☐ **Other Explain:** _____

## PATIENT RIGHTS:

**Is there anything we need to know about your religion or culture in order to care for your child? ____Y ____N**
**If YES, explain:**_____

**Provider Signature:**_____ **Date:**_____

# Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service.

_____ _____
Last Name First Name Middle Initial Date of Birth (Month/Day/Year)

_____ _____
Street Address Apt.#/P.O. Box# (Please include complete mailing address) Medical Record #/Social Security # (Optional)

_____ _____
City State Zip Code Primary Contact Number

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

_____ _____ _____
Business Number Cell Phone Number Other Phone Number

**I authorize the WellStar Medical Group to disclose Protected Health Information to the following persons:**

☐ Parent:_____
Name Phone Number

☐ Other:_____
Name Relationship Phone Number

☐ Other: _____
Name Relationship Phone Number

☐ Other: _____
Name Relationship Phone Number

**Information to be disclosed:**

☐ All Medical Information ☐ Laboratory Results ☐ All Billing/Account Information

*Authorization statement: I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WallStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

**Signature/Date:**
(Date authorization signed by patient or Legal Guardian/Personal Representative) _____
Month/Day/Year

_____ _____
Print Patient Name or Name of Legal Guardian/Personal Representative Signature of Patient or Legal Guardian/Personal Representative

_____
Indicate relationship to patient (required)

**Expiration Date:** This authorization is valid until written notice is provided to revoke this authorization.



Item #105893