

Kennesaw Pediatrics, P.C.

Patient Registration Form

Today's Date: _____

New Patient: _____ Existing Patient: _____ Patient Lives With: _____

Information About Your Child(ren)

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

Parents /Guarantor (Responsible for Payment of Services):

Parent (s) Guarantor Guardian

Parent (s) Guarantor Guardian

Full Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

Occupation: _____

DOB: _____ SSN: _____

Full Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

Occupation: _____

DOB: _____ SSN: _____

Insurance Information

Primary Insurance: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Phone: (____) _____

Insured's Name: _____

Relationship to Patient: _____

Policy Number: _____

Group Number/Name: _____

Secondary Insurance: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Phone: (____) _____

Insured's Name: _____

Relationship to Patient: _____

Policy Number: _____

Group Number/Name: _____

In Case of Emergency (Not Listed Above): _____

Phone: (____) _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

I knowledge my signature indicates consent for treatment of/as patient. I understand that I am financially responsible for payment whether or not services are covered by insurance.

Signature: _____

Date: _____

Kennesaw Pediatrics, P.C.

Patient(s) Family History

Information About Your Child(ren)

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

Full Name _____ DOB _____ Gender: [] M [] F

	<u>DOB</u>	<u>Height</u>	<u>Weight</u>	<u>Medical Problems</u>	<u>Educational Level</u>
Mother:					
Father:					

Is there a family history of any of the following (including child's parents, siblings, grandparents, aunts and uncles)?

<i>Please circle yes or no to all questions.</i>								
	Early Heart Attacks	Yes	No		Kidney Disease	Yes	No	
Allergies	Yes	No		Emotional Problems	Yes	No		Mental Problems
Asthma/Wheezing	Yes	No		Epilepsy	Yes	No		Thyroid Disease
Birth Defects	Yes	No		High blood Pressure	Yes	No		Tuberculosis
Bleeding Tendencies	Yes	No		High Cholesterol	Yes	No		Other Heart Disease
Convulsions	Yes	No		Hip Disorders in Infancy	Yes	No		Other Illnesses
Diabetes	Yes	No		Lazy Eye	Yes	No		

If you answered yes to any of the above, please explain: _____

Social History

Do you and your family have a religious preference? Yes No If yes, please specify: _____

Marital status of parents: Married Single

Has there been a separation, divorce or death? Specify: _____

What has been the attitude of your child to this situation? _____

Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, megavitamins, acupuncture or herbal medicine? Yes No Please specify: _____

Is there a gun in your home? Yes No

Are there pets in your home? Yes No

Does anyone in your home smoke? Yes No

Are there financial problems in the family? Yes No

Are there family disagreements on how to raise this child (ren)? Yes No

With whom does the child(ren) live? (List all household members and their relationship to child(ren):

The name of the person completing this form: _____

The Relationship to patient: _____

Kennesaw Pediatrics, P.C.

Authorization For Medical Treatment in The Absence of Legal Guardian

Your Child(ren) Name:

Full Name _____ DOB _____ Gender: [] M [] F
Full Name _____ DOB _____ Gender: [] M [] F
Full Name _____ DOB _____ Gender: [] M [] F
Full Name _____ DOB _____ Gender: [] M [] F
Full Name _____ DOB _____ Gender: [] M [] F

I am aware that my child may require medical treatment when I am not able to be present. In my absence, I give the individual(s) listed below my permission to authorize any and all medical treatment(s) for my child(ren) named above.

Table with 2 columns: Individual(s) Name, Relationship to Patient. Rows for Full Name: _____

Furthermore in my absence, I give permission to Kennesaw Pediatrics, P.C. and its entire staff to examine and provide emergency treatment to my child (ren) [Listed above]. In addition, the physicians/clinic has my permission to refer my child's emergent care and treatment to the appropriate service physician/hospital/lab/urgent care or medical facility to provide optimal care for the treatment of illness or injury. Regardless of authorization, I acknowledge that I am full responsible for payment of all charges related to my child (ren)'s care whether or not services are covered by insurance.

This authorization becomes effective on _____ and ends _____
DATE DATE or "NEVER"

Parent/Legal Guardian Signature Relationship to Patient Date

How did you find us?

Please indicate below how you heard about Kennesaw Pediatrics, checking all that apply.

1. FRIEND/WORD OF MOUTH (List Name): _____
2. INTERNET SEARCH: GOOGLE KUDZU BING YAHOO OTHER
3. REFERRED BY OBGYN OR HEALTHCARE PROVIDER : _____
4. SAW US AT A COMMUNITY EVENT/FESTIVAL: _____
5. FACEBOOK AD/FACEBOOK PAGE _____
6. MAGAZINE ADVERTISEMENT: AROUND ABOUT ACWORTH COMMUNITY MAGAZINE _____
7. ST. CATHERINE'S CHURCH BULLETIN _____
8. MOVIE THEATER: AMC Barrett Commons Regal Town Center NCG Acworth
9. INTERNET PHONE DIRECTORY: ATT.COM YELLOWBOOK.COM OTHER
10. Printed PHONE BOOK: YELLOWBOOK REAL ATT YELLOW PAGES OTHER
11. KROGER GROCERY CART KROGER OUTSIDE BENCH
12. CHILD CARE CENTER OR SCHOOL: _____
13. OTHER: _____
14. DID YOU VISIT WWW.KENNESAWPEDIATRICS.COM? YES NO

We welcome any comments you may have:
