AGC PEDIATRICS, LLD
PATIENT REGISTRATION FORM

TODAY'S DATE: _____-_____-_____

PATIENT INFORMATION				
Patient's Last Name	First		Middle	
Date of Birth	Age	Sex (Circle One) Male Female	Social Security #	
Street Address		City	State	Zip
Mailing Address (if different from above address)				
Home Phone	Cell Phone	Work Phone	Email Address	

INSURANCE INFORMATION - (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)			
Person Responsible for Bill (Parent's Info even if patient has Medicaid or Peachcare)			
Mailing Address (if different than above)		Date of Birth	Social Security #
Employer	Work Phone	Daytime Phone	Email Address
Is this patient covered by insurance? Yes No (Circle One)			
Insurance Company	Cardholder's Name		Cardholder's Social Security #
Cardholder's Date of Birth	Policy #	Group #	Co-pay $
Name of Secondary Insurance (if applicable)			
Insurance Company	Cardholder's Name		Cardholder's Social Security #
Cardholder's Date of Birth	Policy #	Group #	Co-pay $

Emergency Contact		
Name	Relationship to Patient	Telephone #

Pharmacy Information		
Name of Pharmacy	Location (Street & City)	Telephone #

AGC PEDIATRICS, LLC

204 Professional Ct, Calhoun, GA 30701
PH: 706-625-5900

PATIENT HISTORY INFORMATION

DATE:	CHART NO:
Patient's Name	Birthdate
Mother's Name	Occupation
Father's Name	Occupation
Childcare arrangements	

PREGNANCY HISTORY

Mother's Age at Birth: _____ Baby's due date:_____
Was delivery vaginal or c-section: _____ Birth Weight: _____
Was delivery early, on-time, or late? _____ Birth Length: _____
Circle any of the following complications or usage during pregnancy:

Infection	Diabetes	High Blood Pressure	Hospitalized
Early Labor	Smoking	Alcohol/Drugs	Medications

Did the baby have any of the following problems during or after delivery (circle all that apply):

Infection	Jaundice	Seizures	Breathing Problems
Feeding	Other (please explain) _____		

Has mother had any previous miscarriages or stillbirths? _____

PATIENT'S PAST MEDICAL HISTORY

Where has your child gone for check-ups until now? _____
Date of last check-up _____ Date of last dental check-up _____

List any of the following:
Serious Illness/injuries _____
Childhood Diseases _____
Hospitalization/Operations _____
Current medications _____
Allergic reactions _____
Immunization reactions _____
Recent ER visits _____

Has your child had any problems with (circle all that apply)

eyes	ears	teeth	prolonged colds
seizures	rashes	asthma	chronic cough
heart	urination	bowel habits	anemia

Other (please explain) _____

Patient's Name	Chart No:

FAMILY HISTORY

Who lives in the home? _____

Are Parents: Single _____ Married _____ Divorced _____ Living Together _____

Are both parents in good health? _____

Siblings name _____ Healthy? _____ Age _____

Siblings name _____ Healthy? _____ Age _____

Siblings name _____ Healthy? _____ Age _____

Child's relatives: (please check appropriate column)

1. Good Health	5. Diabetes	9. Mental Problems	13. Alcohol Addiction
2. Poor Health	6. Epilepsy	10. Syphilis G.C.	14. Thyroid
3. Allergies	7. High Blood Pressure/Stroke	11. TB	15. Immune Compromised
4. Asthma	8. Heart Disease	12. Drug Addiction	Cancer, HIV

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Father															
Mother															
Sisters															
Brothers															
Fathers Side															
Mothers Side															

DEVELOPMENT/BEHAVIOR

Age when your child could: sit alone _____ walk _____ talk _____

How does your child compare to others his/her age? _____

_____

What grade is your child in? _____ Any trouble? _____

_____

Does your child get along with other children? _____

_____

Has your child had problems with (circle all that apply)

thumb sucking	bed wetting	toilet training	speech
hyperactivity	nightmares	bad temper	behavior

SAFETY/ENVIRONMENT

Do you live in: House _____ Apartment _____ Mobile home _____ Other _____

Do you know the age of the building in which you live in? _____

Do you know the temperature setting of your water heater? _____

Is there a working smoke detector on each floor of your home? _____

Does your child always use a car seat or seat belt when riding in a car? _____

Does anyone in your home smoke? _____

Are there any problems with the condition of your home? (peeling paint, insects, rodents)

_____

Does your child always wear a helmet when riding a bicycle? _____

AGC PEDIATRICS, LLC
204 Professional Ct, Calhoun, GA 30701
PH: 706-625-5900

Date: _____

Note: Before this document can be valid, it needs to be signed in the presence of a notary republic to be legally notarized.

I _____, the custodial parent/guardian for _____ give permission for the following to seek medical attention and/or receive personal health information about this child.

_____
_____
_____
_____

Signed (Patient or Legal Guardian):	Date:

Sworn and subscribed before me

This _____ day of _____20____

_____

My commission expires: _____

AGC PEDIATRICS, LLC
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
PO BOX 2078, CALHOUN, GA 30703
PH: 706-625-5900 Ext 112 FAX: 706-625-6519

I hereby authorize (name of previous provider) _____ to release all medical records in your possession for:

Patient Name:	Date of Birth:
Address:	Telephone:
	Social Security #

Information to be released (initial if applicable)

	Complete Health Records		Immunization Records

I understand that this will include information relating to any or all of the following:

Behavior health service/psychiatric care
Treatment of alcohol and/or drug abuse
Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus

These records are to be released to:

AGC PEDIATRICS, LLC
PO BOX 2078, CALHOUN, GA 30703
or Fax to: 706-625-6519

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

The facility, its employees, officers and physicians are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed (Patient or Legal Guardian):	Date:

Relationship:	Witness (AGC Staff Member):

AGC PEDIATRICS, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 07/28/2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION - We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $25 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory reasons.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances your explanation how payments will be handled under the alternative means or location you request.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S.
Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S.

How to contact us:

AGC Pediatrics, LLC
Contact Officer: Rhonda M. Jordan
Telephone: 706-625-5900 Fax: 706-625-6519
E-mail: agcpediatrics@bellsouth.net

AGC Pediatrics, LLC
All God's Children
Joseph L. Joyave, M.D.
204 Professional Court
Calhoun, GA 30701

HIPPA Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

AGC PEDIATRICS, LLC

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here:	
Signature:	Date:

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We are not able to communicate with the patient.
- ☐ Other (please provide specific details)

_____

_____

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