AGC Pediatrics, LLC Patient Registration Form

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

Date _____/_____/_____ MRN _____

Patient Name _____ DOB _____/____/_____

	(Please complete if applicable)
Mother's Name_____	Stepfather's Name _____
Mother's Address_____	Stepfather's Address_____
_____ Zip _____	_____Zip _____
Mother's Employer_____	Stepfather's Employer_____
Work # _____ Cell # _____	Work # _____ Cell # _____ ___
Home #_____	Home #_____
Email _____	Email _____

	(Please complete if applicable)
Father's Name_____ _____	Stepmother's Name
Father's Address_____ Address_____	Stepmother's
_____ Zip _____ _____	_____Zip
Father's Employer_____ Employer_____	Stepmother's
Work # _____ Cell # _____ _____	Work # _____ Cell #
Home # _____	Home # _____
Email _____ _____	Email

Marital Status (Circle): Married Single Separated Divorce Widowed

IF DIVORCED: ☐ JOINT CUSTODY ☐ SOLE CUSTODY ☐ LEGAL DOCUMENTS PROVIDED

Patient Information **(Please list ALL Children under 18)**

Legal Name	DOB mm/dd/yyyy	Sex M/F	Child lives with? (Mother/Father/Both)

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

Primary Insurance Information

Insurance Co. _____

Subscriber _____ **Subscriber's DOB** _____/ _____ /_____

Phone: _____ **Member ID:** _____ **Group #:** _____

Secondary Insurance _____ **Subscriber Name:**_____

Member ID: _____ **Group #:** _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial AGC Pediatrics (circle one) **can** **cannot** treat and administer injections/vaccines to my unaccompanied child/children (if over 16 years of age.

_____ Initial I authorize AGC Pediatrics or whoever they designate to evaluate and treat my above named child and to release to our insurance company any information acquired in the course of my child's examination or treatment, and to receive all payments for such examination or treatment. AGC has my permission to release any diagnostic studies, report, etc., to a specialist involved in caring for my child.

_____ Initial I understand that all health care decisions, including immunization authorization, must be made by a legal guardian or parent.

_____ Initial A parent/guardian/ or authorized care giver is to be present at every visit. If someone else is bringing your child, we will need prior written authorization or they will have to be listed on the Designation of another Person to Consent to Medical Care.

PAYMENT POLICIES

_____ Initial **Insurance Information:** Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not present at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for service to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balance**: When insurance information is received after the timely filing requirements of your insurance company, the charges for those services are your responsibility. **You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits.** AGC reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Payments:** AGC accepts cash, checks or credit cards. Payment plans can also be set up by calling our billing department at 706-625-5900 ext. 118.

_____ Initial **Co-Payments:** are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $20 fee. All returned will be subject to a service charge of $35.

_____ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please ask about the Vaccine for Children program.

_____ Initial **Divorced Situations:** The party bringing the child in for care is responsible for payment of co-payments. Both parents are responsible for payment on unpaid balance, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

_____ Initial **Referrals:** If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed *prior* to the specialty appointment.

MEDICAL HISTORY

Pregnancy History

Mother's age at Birth_____ Baby's due date _____ Birth weight _____ Birth length _____

Was delivery **vaginal** or **c-section** (please circle one) Was delivery **early** / **on time** / **late** (please circle one)

Circle any 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) _____

General History

Do you consider your child to be in good health? Yes No DK

Explain _____

Does your child have any serious illnesses or medical conditions? Yes No DK

Explain _____

Has your child had any surgery or been hospitalized? Yes No DK

Explain _____

Is your child allergic to any medications? Yes No DK

Explain _____

Past Medical History **Does your child have, or has your child had:**							
Chickenpox	**Yes**	**No**	**DK**	**HIV**	**Yes**	**No**	**DK**
Problems with ear or hearing	**Yes**	**No**	**DK**	**Chemotherapy**	**Yes**	**No**	**DK**
Heart problems	**Yes**	**No**	**DK**	**Cancer**	**Yes**	**No**	**DK**
Blood transfusion	**Yes**	**No**	**DK**	**Obesity**	**Yes**	**No**	**DK**
Organ Transplant	**Yes**	**No**	**DK**	**Diabetes**	**Yes**	**No**	**DK**
Abdominal pain (Frequent)	**Yes**	**No**	**DK**	**High blood pressure**	**Yes**	**No**	**DK**
Frequent ear infections	**Yes**	**No**	**DK**	**Dental decay**	**Yes**	**No**	**DK**
Allergies (other than Medication)	**Yes**	**No**	**DK**	**History of family Violence**	**Yes**	**No**	**DK**
Anemia or Bleeding problems	**Yes**	**No**	**DK**	**Pregnancy**	**Yes**	**No**	**DK**
Malignancy/bone morrow transplant	**Yes**	**No**	**DK**	**Tobacco use**	**Yes**	**No**	**DK**
Recurrent Urinary Tract Infection	**Yes**	**No**	**DK**				
Congenital cataracts/retinoblastoma	**Yes**	**No**	**DK**	**For girls:**			
Metabolic / Genetic disorders	**Yes**	**No**	**DK**	**Problem with periods**	**Yes**	**No**	**DK**
Bed-wetting (after 5 years old)	**Yes**	**No**	**DK**	**Has had first period**	**Yes**	**No**	**DK**
Thyroid or endocrine problems	**Yes**	**No**	**DK**	**Age at first period**	**Age** _____		
Developmental delay	**Yes**	**No**	**DK**				
History of injures/Fractures/Concussions	**Yes**	**No**	**DK**	**For boys:**			
Use of alcohol or drugs	**Yes**	**No**	**DK**	**Testicular/ Scrotum pain**	**Yes**	**No**	**DK**
History of family violence	**Yes**	**No**	**DK**	**Testicular / Scrotum swelling**	**Yes**	**No**	**DK**
Sexually transmitted infections	**Yes**	**No**	**DK**				
Asthma, bronchitis, bronchiolitis, or pneumonia	**Yes**	**No**	**DK**				
Kidney disease or urologic malformations	**Yes**	**No**	**DK**				
Sleep problems (snoring)	**Yes**	**No**	**DK**				
Chronic or recurrent Skin problems	**Yes**	**No**	**DK**				
Frequent headaches	**Yes**	**No**	**DK**				
ADD/ADHD/ mood problems/ depression	**Yes**	**No**	**DK**				

My signature below indicates I am the parent and/or legal guardian for the patient listed on the front of this page, that I have provided accurate information to the best of my knowledge, and I understand and agree to the provisions as stated.

Signature of Parent / Legal Guardian _____ Date _____

Print Name of Parent / Legal Guardian _____

Please always notify us of any changes to the above information