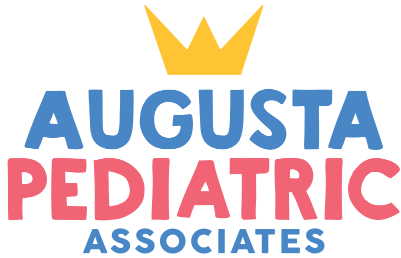

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New Patient Form

Patient's Full Name:____ Birthdate:_________________________ Age:_______________

Sex: _________________________ Has this patient ever been known by any other name?_______________________________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer to Not Answer ☐ Preferred Language:______________________

Race: ☐ Native Am./AK Native ☐ Asian ☐ Black/African Am. ☐ Native Hi/Pacific Islander ☐ White ☐ Prefer Not to Answer

Religious Preference: ____

Preferred Doctor:

☐ Coleman ☐ Drake ☐ Hanna ☐ Lane ☐ Lazari ☐ Leverett ☐ Massey ☐ Newton ☐ Threadgill

Address:____ Best Phone to reach you:___________________________

City:____ State:__________ Zip:_________________ Child's SSN#:___________________

Patient Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other:____

Preferred Method of Contact: Text to _______-_______-_________ Call _______-_______-_________

Please list any siblings that we have seen in this office:____

Best email address: ____@____

Father's Name:____ Social Security #:___________________________

Address:____ Date of Birth:_____________________

City:____ State:__________ Zip:__________________

Employed by:_______________________________________ Work #: ___________________________ Cell #:__________________________

Mother's Name:____ Social Security #:___________________________

Address:____ Date of Birth:_____________________

City:____ State:__________ Zip:__________________

Employed by:_______________________________________ Work #: ___________________________ Cell #:__________________________

Name of Insurance Company:____ Effective Date:___________________________

Policy Number:____ Group Number:____

Policy Holder's Name:____ Date of Birth:____

Does your insurance pay for immunizations/vaccines? ☐ Yes ☐ No ☐ Not Sure Please Initial____________________

PEASE NOTE: We do not submit to secondary insurance plans. We will be happy to provide you with a receipt to submit for reimbursement.

Additional contact person that does not live at the same address (other than relative already listed on this form):

Name ______________________________ Relationship to patient ______________________

Address ____ Phone # ____________________

City ____________________________________ State __________ Zip ______________

How were you referred to our practice? ____

RELEASE OF INFORMATION

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes any physician of Augusta Pediatric Associates, P.C. to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for my dependents and that I am bound by this signature as though the undersigned had personally signed the particular claim.

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay and assign directly to Augusta Pediatric Associates, P.C. all benefits, if any, payable to me for services as described on the attached forms. I further acknowledge that any insurance benefits received by Augusta Pediatric Associates, P.C. will be credited to my account.

PAYMENT AGREEMENT

I give my consent for the examination and treatment of the above named patient including immunizations and injections when indicated and properly authorized. I certify that I am a legal guardian or have been authorized by a legal guardian of the above named patient to consent for examination and treatment. I understand that it is my responsibility to provide Augusta Pediatric Associates, P.C. with the current insurance information. I am aware that payment remains my personal responsibility regardless of insurance or other third party involvement (including court orders). I understand that if at any time a collection agency is employed to collect fees that I am responsible for the fees incurred up to 50% of the balance due. I am aware of the APA financial policy. A copy is available for my review in each exam room, or online at augustapediatrics.com. Payment is expected at time of visit unless prior arrangements have been made. All copays, coinsurance, and deductibles are to be paid at time of service.

REFERENCE LABORATORY SERVICES & SPECIALTY REFERRALS

I understand that Augusta Pediatric Associates, P.C. utilizes the service of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the reference laboratory will bill separately for its services. I consent to Augusta Pediatric Associates, P.C. providing demographic information as necessary for billing purposes. I also recognize that I am responsible for going to a laboratory or specialty referral within my insurance provider's network.

CANCELLATION OF APPOINTMENTS

I understand that I must give a 24 hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

NOTICE OF PRIVACY PRACTICES

I acknowledge by signing below that the Notice of Privacy Practices, Notice of Individual Rights are available to me and are posted for my review in the waiting room.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing

.

____________	______________________________	____________________
Date	Signature of Patient or Parent / Legal Guardian (>18 YO)	Relationship to Patient

Pediatric Database

Name: ______________________________________

Date: _______________________________________

Place of Birth: _______________________________

YES NO ***BIRTH HISTORY***

____ ____ Birth weight greater than 8 lbs. or less than 5 lbs. 8 ounces.

Birth weight ________________lbs.____________________ounces.

____ ____ Premature? Gestational age_______________weeks.

____ ____ C. Section? Reason?____

____ ____ Delivery Problems?____

____ ____ Problems with infection or jaundice?____

____ ____ Other neonatal problems?____

____ ____ Maternal Illness or drugs during pregnancy?____

PAST HISTORY

____ ____ Hospitalizations: ____

____ ____ Drug Allergies: ____

____ ____ Operations: ____

____ ____ Serious illness: ____

____ ____ Serious Accident: ____

____ ____ Present Medications: ____

____ ____ Is the child behind on immunizations? ____

FAMILY HISTORY

____ ____ Significant health problems in parents or brothers or sisters? ____

____

____ ____ High blood pressure, stroke, or heart attack.

____ ____ Diabetes Mellitus

____ ____ Cancer

____ ____ Tuberculosis

____ ____ Seizures or mental retardation

____ ____ Asthma / allergies

____ ____ Sickle Cell Disease

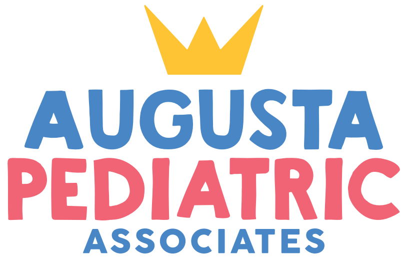
DEVELOPMENT

____ ____ Developmental Delay?

Walked______________months

Talked ______________months

If you answered yes to any question, please explain if there is a blank beside the question.



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Message Authorization

I authorize Augusta Pediatric Associates, P.C. to deliver or cause to be delivered the following types of messages by voice call or text messaging using an automatic telephone dialing system or an artificial or prerecorded voice:

Appointment reminders
Visit recalls
Situational/seasonal service suggestions (Such as flu shot clinics)
Balance due reminders

I authorize such messages to be delivered to the following phone number(s):

________________________________ ________________________________
Cellphone Landline

Please list each child's name.

I understand that by signing the agreement, I am authorizing Augusta Pediatric Associates, P.C. to deliver or cause to be delivered to me certain text messages and/or voice calls and that I am not required to sign this agreement in order to receive services from Augusta Pediatric Associates, P.C.

________________________________ ________________________________ ____________________
Signature Printed Name Date

This consent was revoked on ____________________________.Date

Notify 3/19/19

Joshua Coleman, MD · Jennifer Drake, MD · Aaron Hanna, MD
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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: ____ Date of Birth: ______/_____/______

Patient Name: ____ Date of Birth: ______/_____/______

Patient Name: ____ Date of Birth: ______/_____/______

Best phone to reach you: (______) ____________________ Secondary # (______) ____________________

Address: ____

City: ____ State: ________________ Zip: ______________

INFORMATION TO BE RELEASED FROM:

____
Physicians / Practice Name

____
Street Address

____
City, State, Zip

Phone__________________/Fax____________________

RELEASE TO:

- ▫ Joshua Coleman, MD
- ▫ Jennifer Drake, MD
- ▫ Aaron Hanna, MD
- ▫ Joshua Lane, MD
- ▫ George Lazari, MD
- ▫ Barbara Leverett, MD
- ▫ Jennifer Massey, MD
- ▫ Clark Newton Jr., MD
- ▫ Matthew Threadgill, MD

INFORMATION TO BE RELEASED:

▫ Entire Medical Record ▫ Immunization Record ▫ Labs / X-Rays ▫ Mental Health (Includes ADD/ADHD)

▫ Single Visit - Date of Visit ______/_____/______ ▫Other______________________________________

PURPOSE OF RELEASE:

▫ Continuation of care ▫ Transfer to another provider ▫ Moving ▫ Other: __________________________

I understand that:

- The records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.
- Authorizing the disclosure of this health information is voluntary. If I have questions about disclosure of my health information I can contact the authorized individual or organization making disclosure.
- I may cancel this authorization at any time by submitting a written request to the releasing practice.
- Any disclosure of information carries with it the potential for the further releases or distribution the recipient that may not be covered by confidentiality laws.
- If I authorize Augusta Pediatric Associates to release my records by email many email servers are not a secure means of communication, nor are they obligated to abide by HIPAA regulations that protect my health information. I hold Augusta Pediatric Associates harmless for any undesired results stemming from my request to receive medical records by email or by any other unsecure means.
- My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.
- This authorization will expire in 90 days.

Parents Name: ____________________________________ Phone Number:____________________

____ ____________________
Signature of Parent / Legal Guardian Date