



Joshua Coleman, MD • Aaron Hanna, MD • Josh Lane, MD •  
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Jennifer Mote, MD • Clark Newton, MD • Matthew Threadgill, MD

**1245 Augusta West Pkwy • Augusta, GA 30909**

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## New Patient Form

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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 ☐ Hanna ☐ Lane ☐ Lazari ☐ Leverett ☐ Massey ☐ Mote ☐ Newton ☐ Threadgill

Address:\_\_\_\_\_ Best Phone to reach you:\_\_\_\_\_

City:\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_ Child's #:\_\_\_\_\_

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](http://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



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

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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