

Pediatric Partners, LLC  
1500 Langford Drive, Ste 100  
Watkinsville, GA 30677  
(706) 548-1216

PATIENT INFORMATION SHEET - PLEASE PRINT!!

FULL NAME: \_\_\_\_\_ Nickname \_\_\_\_\_

M or F \_\_\_\_\_ D.O.B. \_\_\_\_\_ School/Daycare \_\_\_\_\_

SIBLINGS: \_\_\_\_\_ D.O.B. \_\_\_\_\_ M or F \_\_\_\_\_  
\_\_\_\_\_ D.O.B. \_\_\_\_\_ M or F \_\_\_\_\_  
\_\_\_\_\_ D.O.B. \_\_\_\_\_ M or F \_\_\_\_\_  
\_\_\_\_\_ D.O.B. \_\_\_\_\_ M or F \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Parents are: \_\_\_\_\_ Child lives w: \_\_\_\_\_  
Race: \_\_\_\_\_ Married \_\_\_\_\_ Mother \_\_\_\_\_  
Preferred \_\_\_\_\_ Divorced \_\_\_\_\_ Father \_\_\_\_\_  
Language: \_\_\_\_\_ Single Parent \_\_\_\_\_ Other \_\_\_\_\_  
Father SS# \_\_\_\_\_

Father: \_\_\_\_\_ D.O.B. \_\_\_\_\_ STATE/DL# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Mother SS# \_\_\_\_\_

Mother: \_\_\_\_\_ D.O.B. \_\_\_\_\_ STATE/DL# \_\_\_\_\_

Mother Maiden Name: \_\_\_\_\_ (Required by Georgia Immunization Registry)

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**EMERGENCY CONTACT INFO:** Please list individuals living outside your home that may be contacted in case of emergency!  
**LIST NAME/ADDRESS/COMPLETE PHONE OR CELL AND RELATIONSHIP TO YOUR CHILD!!**

1 \_\_\_\_\_

2 \_\_\_\_\_

Are individuals listed above authorized to bring your child for medical care? **YES** **NO**  
Preferred method of contact: **Cell#** **Home#** **Work#** **Email** Please provide number or email address above.  
Would you like your physician to pray with your child in case of serious illness? **YES** **NO**

Assignment of Benefits: I authorize payment of medical benefits directly to the physician, realizing that I am responsible to pay all non-covered service, applicable co-pays and deductible amounts. I authorize the release of pertinent medical information to insurance carriers.

RESPONSIBLE PARTY: \_\_\_\_\_ DATE: \_\_\_\_\_

**PEDIATRIC PARTNERS, LLC**

**Medical History – PLEASE PRINT CLEARLY!**

**Patient Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Chronic Problems: M or F**

\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations:**

Date \_\_\_\_\_ Reason \_\_\_\_\_

Date \_\_\_\_\_ Reason \_\_\_\_\_

Date \_\_\_\_\_ Reason \_\_\_\_\_

**Surgeries:**

Date \_\_\_\_\_ Type \_\_\_\_\_

Date \_\_\_\_\_ Type \_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_

**Other – Circle if Applicable:**

Chicken Pox	Eczema	Frequent Ear Infections	Anxiety
Pneumonia	Seizures	Hay Fever	Depression
Meningitis	Measles	Anemia	ADD/ADHD
Asthma	Urinary Infections	Delayed Development	Other Behavioral Issues _____

**Birth History:** Hospital: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Complications \_\_\_\_\_

**Family History – Circle if Applicable:**

Heart attack before age 55	High Blood Pressure	Alcohol/Drug Addiction
Sudden death before age 55	High Cholesterol or Lipid Levels	Eating Disorder
Angina before age 55	Diabetes	Cancer
Stroke before age 55	Tuberculosis	Epilepsy/Seizures
Asthma	Cognitive Disabilities	Kidney Problems
Sickle Cell Anemia	Depression/Anxiety	Hay Fever
Birth Defects	ADD-ADHD/Other Mental Disorder	

**Environmental Factors – Check if Applicable:**

\_\_\_ House built prior to 1960      \_\_\_ Smoking in household      \_\_\_ Pets in household      \_\_\_ Foreign travel  
\_\_\_ Child eats dirt, rocks, etc.      \_\_\_ Attends daycare facility      \_\_\_ Well water

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_