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:_____