# Creekview Pediatrics

caring for your child from birth to 21 yrs

3925 Johns Creek Court
Suite D
Suwanee, GA 30024

Phone (770)622-7742
Fax (770)622-7743



**PATIENT DEMOGRAPHIC FORM / one patient per sheet**

## Patient Information

First Name: ________________ Last Name: ________________ DOB: _______________

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Primary Language: ________________

Please list all children/siblings in the same household:

1) Name: ______________ DOB: __________ 2) Name: _______________ DOB: ____________

3) Name: ______________ DOB: __________ 4) Name: _______________ DOB: ____________

**Initial:** ☐

## Contact Information

With whom does the child reside? _____________

Are parents married? Yes ☐ No ☐ ☐Please list primary caregiver: ________________________

Address: ______________________________________________________________________

City: _______________________________________ State: _________ Zip Code: ________

Mom's Name: _______________ Dad's Name: _____________________

Mom's Maiden Name: ______________ Dad's DOB: ___________________

Mom's DOB: ____________ Dad's Cell Phone# ________________

Mom's Cell Phone# _____________ Dad's Employer: _________________

Mom's Work#_______________ Dad's Work #: ____________________

Mom's Employer: ______________

Emergency Contact Name: _______________ Relation: _______________ Phone#: ________________

**Referred by**: ☐ Friend __________ ☐ Doctor__________ ☐ Insurance__________ ☐ Other_________

**Initial:** ☐

## Responsible party Information

Name: ____________________________ DOB: _______________________

Relationship: _______________________

Address: ______________________________________________________________

Employer's name: ________________________________

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Whom do we call for appointment reminders?
Name: ______________________________ Phone number: _______________________
*Phone # for text messages: _____________________________
Whom do we call for Lab results?
Name: ______________________________ Phone number: _______________________
*Please note normal labs will be published to the portal after reviewed by provider
May we leave results at this number? Yes ☐ No ☐
Whom do we call for Billing?
Name: ______________________________ Phone number: _______________________

Email Address used for patient portal access for child? __________________________________

**Initial:** ☐

## Insurance Information

**Primary Insurance Name**: ___________________Policy Holder's Name: ____________________
Policy holder's DOB: __________________ Policy ID # ___________________________
Group #__________________Policy Holder's relationship with child: _________________
Copay amount: __________________ Coverage dates: __________ to ____________

**Secondary Insurance Name**: ____________________Policy Holder's Name: __________________
Policy holder's DOB: __________________ Policy ID # __________________________
Group #__________________Policy Holder's relationship with child: _________________
Copay amount: __________________ Coverage dates: __________ to ____________

**Initial:** ☐

## Pharmacy Information

**Pharmacy Name**: __________________________Phone #: ______________________
Address: ______________________________________________________________

**Initial:** ☐

I, the undersigned, have insurance with: ___________________________ and assign directly to the physicians at Creekview Pediatrics all surgical and/or medical benefits, if any, payable to me for services. I hereby give permission to physicians at Creekview Pediatrics and the staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

Payment is expected at the time of services. Please feel free to discuss any financial concerns you may have.

Signed By: _____________________________________________ Date: _____________________
Signature of patient or parent/guardian if patient is under 18 years of age

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ___________________________________ DOB: _______________

### ***PLEASE FAX RECORDS TO 770-622-7743***

| I authorize Creekview pediatrics to ***obtain*** information from: | **OR** | I authorize Creekview pediatrics to ***release*** information from: |
|---|---|---|
| Name of provider or facility | | Name of provider or facility |
| Address | | Address |
| City, State, Zip code | | City, State, Zip code |
| Phone # Fax# | | Phone # Fax# |

I am aware if the medical record has information regarding substance abuse mental health, communicable diseases, tuberculosis, or genetics. This information may be released unless indicated by checking here _____

**Records Requested**- please check one

____ **Medical Record:** All growth chart's, recent labs, last well check/ office visit, all immunizations to date, and birth records. ____ **Immunizations only** ____ **Other** (please specify) __________________

**Purpose of disclosure:** ___ Move ___ Transfer of care ___ Insurance change __Personal __Legal

I authorize the release of medical information to another provider/ facility as deemed necessary for my treatment. I further authorize Creekview Pediatrics LLC. To obtain medical information form another provider/ facility as deemed necessary in the course of my treatment. This authorization will expire in sixty (60) days from the date of signature and this authorization may be subject to re-disclosure and longer protection by HIPPA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested. I may cancel this authorization at any time by submitting a written request to Creekview Pediatrics. I understand that the revocation will not apply to information that has already been released to response to this authorization. I understand there is a fee for copying medical records.

All Records require at least 5 business days to process, to protect your privacy, the patient/ legal guardian will be required to pick records up in person and provide valid photo ID. Please provide Phone number to be collected when records are ready for pickup: ______________________________________________

______________________________________________ ____________________________ __________________

Signature of Patient or Authorized Representative Name (please print) Date

(must be 18 years or older)

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## PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: ___________________________________ DOB: _______________

Parent/ Guardian: _________________________________________

I understand that the patient's health information is private and confidential and that Creekview Pediatrics LLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

Creekview Pediatrics LLC. has a detailed document called the "Notice of Privacy Practices." This "Notice" contains detailed information about the policies and practices protecting the patient's privacy and is available for my review at all times. The notice is presented in a manual which is located in the patient reception area. I understand that I have the right to read the "Notice" before signing this Acknowledgment and that I have the right to request and will be given a full, updated copy of the "Notice" upon such a request.

Creekview pediatrics LLC. has established procedures that help them meet their privacy obligations to patient's. These procedures may include other signature requirements, written acknowledgment, and other authorizations, reasonable time frames for requesting information, charges of copies and non- routine information needs, etc. I will assist Creekview Pediatrics LLC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates that I have been given the chance to review a current copy of "Notice of Privacy Practice Creekview Pediatrics LLC."

________________________________________ ___________________ ________________

Patient or legally authorized individual signature Date Time

__________________________________ _________________________________________

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc.)

Name(s) of individuals we may release relevant information to regarding your care

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## CONSENT FOR NON-URGENT PEDIATRIC CARE

Child's Name: ____________________________________ DOB: _______________

Child's Name: ____________________________________ DOB: _______________

Child's Name: ____________________________________ DOB: _______________

Child's Name: ____________________________________ DOB: _______________

Authorized caregiver's information (person other than Mom/Dad)

_____________________ ___________________ ____________________

Caregiver's Name Phone Number Relationship

_____________________ ___________________ ____________________

Caregiver's Name Phone Number Relationship

_____________________ ___________________ ____________________

Caregiver's Name Phone Number Relationship

The above-named caregiver(s) shall be authorized to consent for all medical treatment for the above-named child(ren), which may be required during my absence. Caregiver will be required to present valid picture identification. I agree to be financially responsible for all services provided to my child(ren) authorized by caregiver(s).

I understand that written consent for immunizations will be required from parent(s) or legal guardian. If circumstances permit and/ or if Creekview Pediatrics needs to speak with me, please contact me at the following telephone number: _______________

This consent serves as permission for treatment for the above-named child(ren) by Creekview Pediatrics. **This Authorization shall be in effect until** ____________________

Month day year

This authorization will remain in effect until the date stated above – unless I revoke this authorization in writing and submit it to Creekview Pediatrics prior to this date.

Signature: ______________________ Parent or legal guardian (circle one) Date: _________

Witness: __________________________ Date: __________

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## CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice providers, or other providers have prescribed for you. A variety of sources including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and /or illnesses properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is %100 accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the – counter drugs, supplements or herbal remedies that patients take on their own may not be included

By signing this consent from you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AID/HIV and medicines used to treat mental health issues such as depression.

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**I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**

__________________________________________ __________________

Child's Name Date of Birth

__________________________________________ __________________

Patient/ Parent/ Guardian Signature Date