# 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**

## 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: _____
*Text messages Phone #: _____
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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## 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