SAVANNAH
INTEGRATIVE PEDIATRICS

Patient Demographics

First Name_____Middle_____Last Name_____
DOB_____ Sex: Male Female
Ethnicity Hispanic Non-Hispanic
Language Arabic Cantonese English Hebew Japanese Korean Mandarin Russian Spanish
Race American Indian/Alaska Native Asian Black/African American
Middle Eastern Native Hawaiian/Pacific Islander White/Caucasian Other
Child Lives with: Mother Father Both Other

Emergency Contact	Emergency Phone #	Relationship to Patient

First Responsible Party (Parent/Guardian)

First Name _____Last Name_____
DOB _____Soc. Sec. #_____Drivers License #_____
Relationship to Patient_____Phone #_____
Address_____
City_____ State_____ Zip_____
Email_____

Second Responsible Party (Parent/Guardian)

First Name _____Last Name_____
DOB _____Soc. Sec. #_____Drivers License #_____
Relationship to Patient_____Phone #_____
Address_____
City_____ State_____ Zip_____
Email_____

Insurance Information

Primary Insurance Name_____ ID#_____
Group#_____
Policy Holder (if commercial Insurance)
Name _____ DOB _____
Soc. Sec. # _____
Address (if not the same) _____
City _____ State _____ Zip _____
Who referred you to our practice? _____

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Welcome to our office! Please complete this form as it will help us learn more about your child and allow us to provide the best care.

Pediatric New Patient Record

Patient's Name:_____ Date _____

DOB _____ Drug Allergies_____ N/A

Current Medications _____

Date of your child's last Well Checkup _____

Do you vaccinate your child? Yes No If No, explain why _____

_____

Current Information: List any questions or problems that are concerning you about your child

_____

_____

Does your child currently take vitamins? Yes No If Yes, what type?_____

Pregnancy, Labor, Birth and First week of Life

Did you experience any unusual illness or complications during pregnancy? Yes No If Yes, please explain

_____

Where was your baby born? Hospital Clinic Home Other _____

Was your child born preterm? Yes No If Yes, by how many weeks? _____

What was your baby's weight at birth? _____ lbs _____ oz

Did your baby have any unexpected hospitalizations during the first week of life? Yes No

If Yes, please explain _____

Illness, Allergies and Development

Does your child suffer from any chronic conditions? Yes No If Yes, please explain

_____

Has your child had any surgeries? Yes No If Yes, please explain

_____

Does your child have any allergies ?(other than drug allergies) Yes No If Yes, please explain

_____

Does your child have any special needs? Yes No If Yes, please explain

_____

Has your child ever been hospitalized? Yes No If Yes, please explain

_____

As far as you know, Is your child's development normal? Yes No If No, please explain

_____

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Family History

- Is this child's Father living? ☐ Yes ☐ No What is his age? _____
  Is He in good health? ☐ Yes ☐ No
  Is this child's Mother Living? ☐ Yes ☐ No What is her age? _____
  Is She in good health? ☐ Yes ☐ No

- How many other children are in the family? _____
  What are their ages? _____

- Are your other children in good health? ☐ Yes ☐ No If yes, please explain:
  _____
  _____

- Is there a family history of any type of illness or disease? ☐ Yes ☐ No If yes, please explain:
  _____
  _____

- Do the adults in the family usually agree on the raising of this child? ☐ Yes ☐ No If no, please explain:
  _____
  _____

- Are there significant family or marital problems? ☐ Yes ☐ No
- Are there significant problems in income, housing, or sleeping arrangements affecting your child?
- ☐ Yes ☐ No

Please list any additional problems

_____
_____
_____

PLEASE BRING YOUR CHILD'S IMMUNIZATION RECORD TO THE OFFICE VISIT.

132 Stephenson Ave. Suite 201 Savannah GA, 31405 | 912-567-3700 | Fax 912.567.3701

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NO Show Policy

This policy was established in an effort to reduce the number of No-Show appointments. Exceptions to this policy will be few and limited to true emergencies, thus we are able to provide service to as many patients as possible each day.

Appointment NO-Show Definition: Anytime a patient has an appointment scheduled and either does not come for the appointment or cancels less than one hour prior to their scheduled time.

- **First NO-SHOW**: No action taken, the event is noted in the patient's record and a $25 NO-SHOW fee is charged.

- **Second NO-SHOW**: A letter is sent to the patient/guardian and their insurance carrier documenting two incidents of not coming for scheduled appointments. A $25 NO-SHOW fee is charged.

- **Third NO-SHOW**: The patient (and entire family) will be discharged from our care. A letter is sent to the patient/guardian and their insurance carrier. A $25 NO-SHOW fee is charged. *NOTE: We will not reinstate families that have been discharged from the practice.*

Please list each Child in your family

_____ DOB _____
_____ DOB _____
_____ DOB _____
_____ DOB _____
_____ DOB _____
_____ DOB _____
_____ DOB _____
_____ DOB _____

_____ _____

Parent/Guardian's Signature Date

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Assignment and Release

- I hereby authorize the release of pertinent medical information to insurance carriers.
- I hereby authorize my insurance benefits to be paid directly to Savannah Integrative Pediatrics.
- I understand that all charges for professional services performed are my financial responsibility, regardless of insurance coverage that I may have.
- I agree to pay any and all co-pays and deductibles at the time of service.
- I understand that it is my responsibility to be aware of my insurance policies regarding payment for services, including office procedures and lab fees.
- I am aware that any balance unpaid by my insurance is my responsibility.
- I understand that unwillingness to resolve any balance within 90 days from the date of service will result in dismissal from the practice and legal action may take place.

Printed name of responsible party

_____

Relationship to Patient

_____

Signature of responsible party _____ Date _____

I, _____, have read, understand, and agree to Savannah Integrative Pediatrics office policies and procedures regarding: appointments, telephone calls, financial responsibilities, medical records, documents and prescriptions.

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Authorization to use/Disclose protected Health Information

I hereby authorize the use or disclosure of the named individual's health information as described below:

Patient Name _____ DOB _____

Address _____ Phone _____

_____

_____

I am requesting medical records to be obtained FROM:

_____

_____

Please send records TO:

_____

_____

Reason for the Request: _____

The following information is to be disclosed: Check the box(es) that apply

☐ All Medical Records ☐ Immunization Records ☐ Lab Results

☐ Daycare Forms ☐ X-rays ☐ Sports/Camp Forms

☐ Other _____

Sensitive Information: I understand that the information in my record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time, I understand that my revocation must be in writing.. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization. It is strictly voluntary, I do not need to sign this form to assure treatment. I also understand that I may inspect and obtain a copy of the information to be used or disclosed for a reasonable fee.

Expiration Date _____ unless otherwise revoked, this authorization will expire on this date.

_____ _____

Signature of Parent/Guardian/Self(if over 18) Date

_____

Relationship to Patient

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