



FAMILY REGISTRATION FORM

Use each child's legal name and include every child you are registering under this account.

Child's Name _____	DOB ____/____/____	Male ____	Female ____
Child's Name _____	DOB ____/____/____	Male ____	Female ____
Child's Name _____	DOB ____/____/____	Male ____	Female ____
Child's Name _____	DOB ____/____/____	Male ____	Female ____

PARENT/GUARDIAN INFORMATION

Name _____ **DOB** _____
Relationship to Patient: ☐Mother ☐Father ☐Other Guardian ☐Other

Street Address _____ *City* _____ *State* ____ *Zip* _____

Primary Phone _____ *Work Phone* _____

Employer _____ *E-mail* _____

Name _____ **DOB** _____
Relationship to Patient: ☐Mother ☐Father ☐Other Guardian ☐Other

Street Address _____ *City* _____ *State* ____ *Zip* _____

Primary Phone _____ *Work Phone* _____

Employer _____ *E-mail* _____

Parents/Guardians are: ☐ Married ☐ Divorced ☐ Other

Child(ren) live(s) with ☐ Mother ☐ Father ☐ Both ☐ Other

Mother's Maiden Name (for immunization registry purposes) _____

Which physician does your child see? _____

Emergency Contact (other than parent/guardian) _____ **Phone** _____

Relationship _____

Please provide a copy of your current insurance card at every visit.

Insurance Co. _____ **ID** _____ **Group #** _____

Policyholder's Name _____ **DOB** _____ **Relationship to Patient** _____

Parent/Guarantor Signature

Printed Name

Date

NORTH ATLANTA PEDIATRIC ASSOCIATES, P.C.
FINANCIAL POLICY

Thank you for choosing North Atlanta Pediatrics as your healthcare provider. The following is a summary of our Financial Policy. We require that you read and sign our policy prior to treatment.

Due to frequent changes in health insurance coverage, we request that you provide proof of insurance coverage at each visit.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

All co-payments, coinsurance, and deductibles are due at the time of service unless other arrangements have been made in advance. These fees cannot be waived. **If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan that we do not participate in, full payment is required at the time of your visit. For your convenience we accept cash, check, Visa / MasterCard, American Express and Discover. Any checks returned unpaid by your financial institution will be subject to a fee of \$35.**

All co-pays NOT collected at the time of service will incur a \$10 billing fee. Please also be aware that some services provided may be non-covered services and not reimbursable by your insurance. You are personally responsible for these services.

Financial arrangements for balances due can be made through a payment program. Failure to resolve any past due accounts, including returned checks, may result in referral to a collection agency. You may be responsible for any fees associated with the costs of collections in addition to the amount owed on the account. Any family whose account is forwarded to a collection agency may be discharged from our practice.

INSURANCE

We bill participating insurance companies for your visit. **Please note: We do not bill secondary insurance companies.** You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note that your insurance policy is a contract between you and your insurance company, therefore, you are responsible for being sure all charges are paid whether by you or your insurance company.

ANNUAL ADMINISTRATIVE FEE

Effective January 1, 2024, we will assess a \$20 annual administrative fee to all patient accounts. This fee replaces individual per-form and supplemental charges. It ensures our patients receive dedicated access to our 24-hour nurse advice line, care coordination, referrals, and completion of standard school, camp, and sports physical forms within 3 business days (72 hours). Please note that expedited requests, including ADHD medication refills and rush forms, will still incur a separate \$20 rush fee. Alternatively, you may opt out of the annual fee and pay a \$10 fee per individual form.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Please provide at least **24 hours' notice** when canceling or rescheduling appointments so we may offer that time to another patient. There is an \$80 charge for missed appointments or late cancellations. Excessive abuse of scheduled appointments may result in discharge from the practice.

Divorce, Separation, & Custody Agreements

North Atlanta Pediatric Associates collect copays and deductibles from the attending parent at the time of service. Copies of these charges are available at the request of the attending parent. Each parent is responsible for providing correct billing information for their child. Incorrect billing information or lack of billing information will necessitate billing the attending parent at the time of service. If a parent is legally excluded from participation in any form of medical care for their child, North Atlanta Pediatric Associates requires documentation from the court as part of our medical record.

Parent/Guardian Signature

Date

ASSIGNMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION

I authorize the release of any medical or other information necessary to process my child's insurance claim. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to North Atlanta Pediatric Associates for services rendered and agree to abide by the financial policies of North Atlanta Pediatric Associates.

I acknowledge that I have read and understand the policies stated above. I agree to pay any monies due at the time of service and provide accurate insurance information to assist North Atlanta Pediatrics in timely filing and prompt payment of my claims. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I may also be responsible for the fee charged by the collection agency for costs of collections.

Parent/Guardian Signature

Date

If I am unable to be reached, I give my permission to North Atlanta Pediatric Associates to treat my children.

Parent/Guardian Signature

Date

6/3/2026

Notice of Privacy Practices Written Acknowledgement Form

I acknowledge that I have received/reviewed a copy of North Atlanta Pediatric Associates, PC's "Notice of Privacy Practices" for protected health information on the date set forth below.

Parent/Guardian/Patient Signature

Date

My children and their dates of birth are:

Patient Name

Date of Birth

Patient Name

Date of Birth

Patient Name

Date of Birth

Patient Name

Date of Birth

FOR USE BY NORTH ATLANTA PEDIATRIC ASSOCIATES, PC PERSONNEL ONLY

Complete if patient acknowledgement is not obtained.

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

_____ Parent/Patient refused to sign acknowledgement

_____ Unable to gain signed Acknowledgment due to communication / language or other barrier

_____ Parent/Patient was unable to sign Acknowledgment due to emergency treatment situation

_____ Other (please indicate reason):

Signature of North Atlanta Pediatrics
Representative

Date



Follow My Health is a secure patient portal that allows patients to access their health information. Key features include:

- View dates and times of scheduled and past appointments
- Request Prescription Refills (including ADD/ADHD Refills)
- Update demographic information
- View information pertaining to office visits including vital signs, immunizations, and prescribed medications
- Remain up to date on important office announcements and reminders
- Download or print Camp/ School Registration Forms
- View account balance statements and pay your bill online

PATIENT PORTAL REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

PARENT/GUARDIAN (AUTHORIZED INDIVIDUAL) INFORMATION

Parent/Guardian Name: _____

Address: _____

Email Address: _____ Phone #: _____



1100 Lake Hearn Drive
Suite 100
Atlanta, GA 30342

Pediatric Sudden Cardiac Risk Assessment

Patient Name (Please Print)

Date of Birth

Physician Your Child is Seeing Today (Please Print)

Date of Appointment

Ask these questions (or have parents complete for your review) at periodic time during well child visits: (neonatal, preschool, before/during middle school, and before/during high school).

Patient History Questions: Tell me about any of these in your child:	Yes	No
Has your child fainted or passed out DURING exercise, emotion or startle?		
Has your child fainted or passed out AFTER exercise?		
Has your child ever had extreme shortness of breath during exercise?		
Has your child ever had discomfort, pain or pressure in his/her chest during exercise?		
Has a doctor ever ordered a test for your child's heart?		
Has your child ever been diagnosed with an unexplained seizure disorder or exercise induced asthma not well controlled with medication?		
Family History Questions: Tell me about any of these in your family:		
Are there any family members who died suddenly of "heart problems" before age 50?		
Are there any family members who have unexplained fainting or seizures?		
Are there any relatives with certain conditions, such as:		
Enlarged Heart: Hypertrophic cardiomyopathy (HCM)		
Dilated cardiomyopathy (DCM)		
Heart Rhythm problems: Long QT Syndrome (LQTS)		
Short QT Syndrome		
Brugada Syndrome		
Catecholaminergic ventricular tachycardia		
Arrhythmogenic right ventricular cardiomyopathy (ARVA)		
Marfan Syndrome (aortic rupture)		
Heart Attack, age 50 or younger		
Pacemaker or implanted defibrillator		
Deaf at birth (congenital deafness)		
Please explain any "yes" answers:		

Parent Signature

Date

Physician Signature

**To be filed in patient chart

04/26



1100 Lake Hearn Drive
Suite 100
Atlanta, GA 30342

Screening Questions for TB Risk Factors

Please complete this form and give it to your physician when they come into the room

Patient Name (Please Print)

Date of Birth

Physician Your Child is Seeing Today (Please Print)

Date of Appointment

Yes	No	
		Was your child born outside the US? If so, where?
		Has your child traveled outside the US? If so, where?
		Has your child been exposed to anyone with TB disease?
		Does your child have close contact with a person who has a positive TB skin test?
		Does your child spend time with anyone who has been in jail (or prison), has been in a shelter, uses illegal drugs, or has HIV infection?
		Has your child consumed raw milk or unpasteurized cheese?
		Was any member of your household (including caretakers, etc.) born outside the US? If so, where?
		Has a member of your child's household (including caretakers, etc.) traveled outside the US within the last 6 - 12 months? If so, where?

Physician Comments:

Physician Signature

****To be filed in patient's chart**

Patient's Name: _____ Date of Birth: _____

FAMILY HISTORY

	Date of Birth	Ht.	Wt.	Medical Problems	Educational Level
MOTHER					
FATHER					

Is there a family history of any of the following (please include the child's parents, siblings, grandparents, aunts and uncles)?

Please check yes or no to all questions.

Diabetes	☐ Yes ☐ No	Bleeding Tendencies	☐ Yes ☐ No
Asthma / Wheezing	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Early Heart Attacks	☐ Yes ☐ No
Mental Problems	☐ Yes ☐ No	Other Heart Disease	☐ Yes ☐ No
Emotional Problems	☐ Yes ☐ No	Hip Disorders in Infancy	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Birth Defects	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Other Illnesses	☐ Yes ☐ No		

If you answered yes to any of the above questions above, please explain: _____

SOCIAL HISTORY

- Do you and your family have a religious preference? ☐ Yes ☐ No If yes, please specify: _____
- Marital status of parents: ☐ Married ☐ Single
- Has there been a separation, divorce, or death? ☐ Yes ☐ No If yes, please specify: _____
- Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, megavitamins, acupuncture or herbal medicine? ☐ Yes ☐ No If yes, please specify: _____
- Is there a gun in your home? ☐ Yes ☐ No
- Are there pets in your home? ☐ Yes ☐ No
- Does anyone in your home smoke? ☐ Yes ☐ No
- Are there financial problems in the family? ☐ Yes ☐ No
- Are there family disagreements on how to raise this child? ☐ Yes ☐ No
- With whom does the patient live? (List all household members and their relationship to the patient.)

PREGNANCY HISTORY WITH THIS CHILD

- Have you had breast surgery? ☐ Yes ☐ No
- Did you take hormones during pregnancy? ☐ Yes ☐ No
- Did you take any drugs during pregnancy? ☐ Yes ☐ No
- Did you smoke during pregnancy? ☐ Yes ☐ No
- Did you drink any alcoholic beverages during pregnancy? ☐ Yes ☐ No
- Has the child's mother had any miscarriages, stillbirths, or abortions? ☐ Yes ☐ No If yes, please list:

BIRTH HISTORY OF CHILD

- Full term pregnancy? ☐ Yes ☐ No Premature Birth? ☐ Yes ☐ No If yes, how many weeks? _____
- Adopted? ☐ Yes ☐ No If yes, at what age? _____ Has the child been told they are adopted? ☐ Yes ☐ No
- Where was your child born? _____ Obstetrician: _____
- Birth Weight: _____ Length: _____ Head Cir: _____ Apgars: _____
- Breast fed ☐ Yes ☐ No Bottle fed ☐ Yes ☐ No
- Any problems at birth? ☐ Yes ☐ No If yes, please specify: _____

CHILD'S DEVELOPMENT

Please list age of child when the following milestones were reached:

Sat alone at _____ mos.	Walked at _____ mos.	Words at _____ mos.	Sentences at _____ mos.
First teeth at _____ mos.	Bowel trained at _____ mos.	Bladder trained at _____ mos.	

Does the child have any handicap? ☐ Yes ☐ No If yes, please specify: _____

SCHOOL PERFORMANCE

Scholastic performance:

- Academic: _____
- Behavior: _____

Has your child ever been in a special education class? ☐ Yes ☐ No

Has your child had a learning problem? ☐ Yes ☐ No If yes, please specify: _____

PAST ILLNESSES

Please mark the date or frequency of illness or specify substance causing allergy.

Roseola		Asthma		Rubella (German Measles)	
Chicken Pox		Heart Murmur		Allergic to Medication	
Mumps		Colds		Allergic to Foods	
Tonsillitis		Scarlet Fever		Allergic to Insect Bites	
Pneumonia		Ear Infections		Has patient received desensitization shots?	☐ Yes ☐ No
Convulsions		Urinary Infections		Other	

OPERATIONS AND HOSPITALIZATIONS

Please specify the date or reason:

Appendectomy		Tonsils and Adenoids		Ear Tubes	
Other Operations:					
Other Hospitalizations:					

MEDICATIONS

Is your child taking any medication on a regular basis? ☐ Yes ☐ No If yes, please specify: _____

CHILD'S PREVIOUS PEDIATRICIAN

Name: _____ Phone #: (_____) _____

ANYTHING ELSE ABOUT YOUR CHILD?

Is there anything else about your child you feel we need to know to provide the best medical care for him / her?

Physician's Signature: _____