PEDIATRIC PARTNERS, LLC
1500 LANGFORD DRIVE, STE 100
WATKINSVILLE, GA 30677 706-548-1216

Patient Information Sheet- PLEASE PRINT

FULL NAME: _____ Date of Birth: _____ M or F
Nickname_____ School/Daycare_____

SIBLINGS: (THAT ARE PATIENTS OF PEDIATRIC PARTNERS)

FULL NAME: _____ Date of Birth: _____ M or F

FULL NAME: _____ Date of Birth: _____ M or F

FULL NAME: _____ Date of Birth: _____ M or F

FULL NAME: _____ Date of Birth: _____ M or F

FULL NAME: _____ Date of Birth: _____ M or F

Ethnicity: _____
Race: _____
Preferred Language: _____

Parents are: Married _____ Divorced _____ Single Parent _____
Child lives with: Mother(s) _____ Father(s) _____
Step Mother/Father _____ Guardian/Foster _____

MOTHER/FATHER/Guardian: _____ **DOB:** _____

Maiden Name: _____ (Required by Georgia Immunization Registry)

SSN# _____ **State DL#** _____

Address: _____ City: _____ County: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Cell Phone: _____ **Email:** _____

FATHER/MOTHER/Guardian: _____ **DOB:** _____

SSN# _____ **State DL#**_____

Address: _____ City: _____ County: _____ Zip: _____

Home: _____ Employer: _____ Work Phone: _____

Cell Phone: _____ **Email:** _____

Emergency Contact Info: Please list individuals living outside the 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 or NO
-Preferred Contact Method: Cell# Home# Work # EMAIL Please provide number and/or email ABOVE.
-Would you like your physician to pray with your child in case of serious illness? YES or 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 medical information to insurance carriers.

Responsible Party Signature: _____ Date: _____
PRINT NAME:_____Relationship: _____

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:_____