SANDBAR Pediatrics
BRUNSWICK, GA

Patient Demographic Information

Date: _____

Patient Name: _____ DOB:____/____/____ Sex: F [ ] M [ ]

Race: [ ] Refuse [ ] Caucasian [ ] Black/African American [ ] American Indian/Alaska Native [ ] Asian [ ] Hispanic [ ] Vietnamese [ ] Pacific Island/Hawaiian [ ] Other _____ **Ethnicity**: [ ] Refuse [ ] Hispanic/Latino [ ] Non-Hispanic/Latino

Language: [ ] English [ ] Spanish [ ] Other: _____ Interpreter Needed? [ ] Yes [ ] No

Mailing Address: _____ City/State: _____ Zip Code: _____

Alternate Address: _____ City/State: _____ Zip Code: _____

Primary Phone Number: _____ Alternate Phone Number: _____

PCP: _____ Phone Number: _____

Responsible Party Information

Relationship to patient: _____ Name of Parent/Guardian _____

DOB: _____ Primary Phone Number: _____ Employer: _____

Relationship to patient: _____ Name of Parent/Guardian _____

DOB: _____ Primary Phone Number: _____ Employer: _____

Patient Portal

Sandbar Pediatrics offers a patient portal, where you can access your child's medical information online, anytime, as well as schedule appointments, and send communications to office staff. Please provide us with your email if you would like to sign up. You may access your patient portal via the ***Healow*** app.

Would you like to sign up? [ ] Yes [ ] No

Email Address: _____

Pharmacy Information

Name: _____ Phone Number: _____

HIPAA Contacts

Name of person(s) you wish to receive any test results, medical or billing information on your behalf including *anyone you wish to accompany your child to office visits*:

Name: _____ Relationship to you: _____

Date of Birth: _____ Primary Phone #: _____

Name: _____ Relationship to you: _____

Date of Birth: _____ Primary Phone #: _____

Name: _____ Relationship to you: _____

Date of Birth: _____ Primary Phone #: _____

□ Check box if you would like yourself to be your **only** HIPAA contact.

I acknowledge that this HIPAA authorization remains in effect until I give written notification to discontinue.

Insurance Information

Do you have insurance? □ Yes □ No **Self Pay, please check this box □

Sandbar Pediatrics offers a sliding fee discount program for uninsured and underinsured, would you like to apply? □ Yes □ No

Primary Insurance: _____ Subscriber Number: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance: _____ Subscriber Number: _____

Policy Holder Name: _____ DOB: _____

Tertiary Insurance: _____ Subscriber Number: _____

Policy Holder Name: _____ DOB: _____

Authorization to Pay and Acceptance of Responsibility

I hereby authorize payment directly to Sandbar Pediatrics for all insurance benefits otherwise payable to me for services rendered. I understand that I am responsible for any balance not paid by my insurance. Co-payments are due at the time of service. This is a contract between you and the insurance carrier and must be collected. For scheduled appointments, prior balances must be paid prior to the visit.

X _____

Signature (Parent/Guardian if Patient is under 18) Date

Vaccine Policy Statement

Recent CDC vaccine guidance does not reflect an evidence-based change in safety or effectiveness. For that reason, our practice will continue to follow the American Academy of Pediatrics (AAP) recommendations, which align with the prior CDC guidelines and are supported by the best available pediatric evidence.

Vaccinations are an important part of keeping your child's health and the timing is critical. The American Academy of Pediatrics immunization schedule is designed so that kids and infants are protected from dangerous illnesses like measles, mumps, polio, and various forms of hepatitis at the earliest age that is healthy for them. Each year, the immunization schedules are evaluated by top experts and pediatric specialists throughout the country, using the most up-to-date knowledge and research to make any possible improvements. For this reason, it is important that parents speak with their board-certified pediatrician to find out the current recommendations and to schedule their child's immunizations.

At each well-child visit, we at Sandbar Pediatrics, will discuss any upcoming vaccines your child will need as well as any vaccines that are already due for your child.

Sandbar Pediatrics **does not** accept families who do not intend to vaccinate their infants. If an alternate vaccination schedule is requested, immunizations must begin by 6 months of age, with a plan in place to complete the primary vaccination series by 2 years of age. This agreement must be signed by the parent/guardian and followed as outlined. Failure to comply with the agreed-upon vaccination plan will result in dismissal from the practice.

We are also **unable** to accept transfers of unvaccinated children over 6 months of age into our practice. Families transferring to Sandbar Pediatrics must provide documentation within 30 days demonstrating that all vaccines currently due, according to the American Academy of Pediatrics (AAP) recommended immunization schedule, have been administered.

We are always happy to discuss any questions or concerns with you individually. Our shared goal is to keep your child healthy, protected, and thriving.

Patient Eligibility Screening Record

Vaccines for Children Program

This provider participates in the Vaccines for Children Program (VFC). If you meet the requirements of this program, we can provide your child's immunizations at a reduced fee. In order to determine eligibility, we must know if your child has insurance that pays for immunizations.

Patient Name: _____ DOB:_____/_____/_____

INELIGIBLE FOR STATE-SUPPLIED VACCINE (Check if applicable)

☐ **The child 18 years of age or younger has insurance that pays for immunizations. (Fully-insured / Private Pay, includes high-deductible plans)**

ELIGIBLE FOR STATE-SUPPLIED VACCINE

This child 18 years of age or younger qualifies for vaccination with state-supplied vaccine because (check only one box):

☐ The child is enrolled in Medicaid
☐ The child is enrolled in PeachCare for Kids
☐ The child is American Indian or Alaska Native
☐ The child does not have health insurance (Not Insured)
☐ The child has health insurance that does not pay for vaccines (Underinsured)

X _____

Signature (Parent/Guardian if Patient is under 18) Date

Authorization and Agreement for Treatment

Consent to Treatment: I understand that medical treatment is necessary for the patient and that such medical care, treatment, and procedures will be performed by Sandbar Pediatrics employees. I hereby grant my authorization and consent to such treatment and procedures and certify that no guarantee or assurance has been made to the results which may be obtained.

Protected Health Information Disclosure: I hereby authorize Sandbar Pediatrics to release my medical information in connection with these services for health insurance purposes or to the patient's personal physician or to a referral physician. I authorize direct payment of all benefits to Sandbar Pediatrics and authorize submission of insurance forms with this signature on file. I give permission for my Protected Health Information to be disclosed for purposes of communicating results and care decisions to the family members and others selected for PHI disclosure.

No Show Policy: We understand that events may occur that keep you from attending your scheduled appointment, however, you need to let us know in advance. This will allow us to see other patients who may need to be seen during that time. Our policy is that if a patient misses three visits without notification within a 12-month time period, we reserve the right to dismiss the patient.

Medical Records/Form Fees: Medical records are the property of the Practice. I may request copies of medical records by completing a medical records request form. Copies required for the continuation of care are free of charge. The Practice will provide copies within 30 days of receiving a written request. FMLA forms or any additional forms are subject to a $25.00 fee. Medical form requests require 72 hours for processing.

Student Observation/Assistance: I consent that students, including fellows, residents, Physician Assistants students, Medical Students, interns, clinical nursing or technical students, and manufacturing or company representatives, may observe or assist in the care which will be undertaken at Sandbar Pediatrics.

Consent for Patient Reminders and Notifications: You are consenting to receive messages from us, your healthcare provider, that utilizes an automatic telephone dialing system to deliver a text, voice, or pre-recorded message that may contain health related information or healthcare management advice at the telephone number(s) that you have provided. You understand that you are not required to provide consent in order to receive such information or advice from your healthcare provider. Your request to receive automated voice and text messages from us, your healthcare provider, constitutes your agreement to these terms and conditions. You agree that we may send you automated voice and text messages through your wireless provider to the valid mobile or landline number that you have provided us. You agree to indemnify, defend, and hold us, our technology service vendor - Healow LLC, our electronic medical record vendor - eClinicalWorks LLC, and its affiliated companies harmless from any third-party claims, liability, damages or costs arising from your request to receive automated voice or text messages or from providing us, your healthcare provider, with a phone number that is not your own. You agree that we and our technology solution vendors will not be liable for failed, delayed, or misdirected delivery of, any information sent to you or from you, including opt-out requests.

Patient Acknowledgement: I acknowledge that I have been provided with an opportunity to receive the *Sandbar Pediatrics* Notice of Privacy Practices and have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that I may request a printed copy of the Notice at any time. I also understand Sandbar Pediatric providers may use ambient listening technology, which is software that records information spoken by me, my personal representatives, and my care team and transcribes the information into my medical record. I can opt out of the use of this technology at any time by informing my care team. I further acknowledge that I may request a chaperone during my care, even when I have brought another person with me. For certain examinations, a chaperone will be provided automatically. If I want a chaperone, I will notify my care team.

I have read and fully understand the above acknowledgments and agreements.

X _____

Signature (Parent/Guardian if Patient is under 18) Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NOTE: Complete <u>One</u> Form Per Patient

PATIENT INFORMATION:

Name _____ Date of Birth _____

Street Address _____

Email Address _____ Phone Number _____

RELEASE MEDICAL RECORDS FROM:

Name _____

Phone Number _____

Street Address _____

Email Address / Fax Number _____

RELEASE MEDICAL RECORD TO:

Sandbar Pediatrics
Name

(912) 694-1094
Phone Number

617 Palisade Drive Brunswick, GA 31523
Street Address

info@sandbarpediatrics.com / (912) 694-1095
Email Address / Fax Number

DATES OF SERVICE: _____

MEDICAL RECORDS TO BE RELEASED: (REQUIRED - Check Items Below)

☐ Office Visits- i.e. progress notes, medication list, medical history
☐ Laboratory Reports- i.e. bloodwork, cultures
☐ Radiology Reports- i.e. x-rays
☐ Echoes- i.e. cardiology
☐ Immunization Records
☐ Growth Charts
☐ Referral- specialists
☐ Itemized Bills
☐ Other (please specify): _____

(REQUIRED) ☐ I DO ☐ I DO NOT authorize the release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse (INITIALS): _____

PURPOSE OF RELEASE: (REQUIRED)

☐ Personal Copy
☐ Transfer of Care (Specify Reason):
☐ Disability Determination
☐ Moved
☐ Other (Please explain): _____
☐ Insurance Purposes
☐ Insurance Change
☐ Legal Matter
☐ Graduated to Adult PCP

SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT (IF PATIENT IS 18 YEARS OR OLDER):

I acknowledge I am a legal representative, or an authorized person of the patient listed above. By signing below, I am authorizing the release and disclosure of the patient's protected health information. This authorization is valid 12 months from the date of signature. I understand that I may cancel this request with written notification, and it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that I may be compensated if this information is used for marketing and sales. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether I sign the authorization.

Signature of Legal Representative/Patient 18yrs or older _____ Date _____

Print Name of Legal Representative/Patient 18yrs or older _____ Relationship to Patient _____

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____ Age _____ Male _____ Female _____

Mother's Name _____ Father's name _____

Form filled out by _____ Date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications _____

Delivery by ☐vaginal ☐c-section

Reason for c-section _____

Complications _____

Was your child premature ☐No ☐Yes, born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease _____
- ☐Wheezing or bronchiolitis _____
- ☐ Seasonal allergies or eczema _____
- ☐ Food allergy _____
- ☐ Recurrent ear infections _____
- ☐ Pneumonia _____
- ☐ Urinary tract infections _____
- ☐ Genetic syndrome _____
- ☐ Seizures _____
- ☐ Anemia _____
- ☐ Broken bone _____
- ☐ Mental retardation or learning disability _____
- ☐ Depression/anxiety _____

Other chronic medical conditions _____

_____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

_____

_____

Previous surgeries and dates _____

_____

Previous pediatrician _____

Please list any specialist your child is currently seeing and reason:

_____

_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

_____

_____

Current medications and dose: _____

_____

_____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Development/Nutrition

At what age did your child:

Walk alone _____ Sit alone _____

Toilet train(day) _____ Say words _____

Was your child breastfed ☐ No ☐Yes, how long? _____ 1st period (females) _____

Has your child had any unusual feeding/dietary problems? Explain.

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____

☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Mother's occupation _____

Father's occupation _____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

School's name _____ Grade _____

Any concerns about school performance? ☐ No ☐ Yes, explain

_____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____ Computer _____ Video games _____

Sports/exercise: Type _____

How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____

_____

_____

_____

Review of Systems (*Check all that apply*)

Constitutional
☐ Fever, chills ☐ Fatigue
☐ Unexplained weight loss/gain
☐ Excessive thirst

Ear, Nose, and Throat
☐ Loud voice, hearing problem
☐ Mouth-breathing, snoring
☐ Ear pain
☐ Frequent runny nose

Respiratory
☐ Cough, short of breath
☐ Chest tightness, wheeze

Musculoskeletal
☐ Muscle pain, weakness
☐ Joint pain, swelling
☐ Bone pain

Other (eye,skin,blood)
☐ Blurry vision ☐ Squinting
☐ "Crossed" eyes ☐ Itchy eyes
☐ Rashes ☐ Abnormal moles
☐ Abnormal bruising, bleeding

Gastrointestinal
☐ Nausea, vomiting, diarrhea
☐ Constipation, blood in stool
☐ Abdominal pain

Cardiovascular
☐ Chest pain, palpitations
☐ Tires easily with exertion
☐ Fainting

Genitourinary
☐ Frequent or painful urination
☐ Bedwetting, frequent accidents
☐ Vaginal or penile discharge

Neurologic
☐ Headaches ☐ Seizures
☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
☐ Anxiety/stress ☐Depression
☐ Sleep problem ☐ Anger concern
☐ Concerns with attention, impulsivity