Suwanee Pediatrics
1155 Lawrenceville-Suwanee Rd, Lawrenceville, GA 30043
Phone: (678) 442-0205 | Fax: (678) 442-0185
www.SuwaneePediatrics.com
contact@suwaneepediatrics.com

Patient Information

Patient's Name _____
First Middle Last

DOB_____ **Age** _____ **Sex** _____ **SSN**_____

Home Address _____

City_____ **State**_____ **Zip Code**_____

Allergies to Medicine/Food_____

Do you have children that are established Patients at Suwanee Pediatrics? NO / YES, please list the Name and D.O.B. of children:

_____

_____

Primary Phone: (_____) _____ - _____
Secondary Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Email: _____

Child in Legal Custody with	☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other
Child Legally Resides with	☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other

***** Any custody issues we need to be aware of? (Discuss with MD) *****

Mother/ Guardian Name:		
Home Address		
Personal/Work Phone #'s	(_____) _____ - _____	(_____) _____ - _____
Date of Birth		SSN:
Pertinent Health History		

Father/ Guardian Name:		
Home Address		
Personal/Work Phone #'s	(_____) _____ - _____	(_____) _____ - _____
Date of Birth		SSN:
Pertinent Health History		

Please list the family members or other persons whom we may inform about your child(ren's) medical condition ONLY IN EMERGENCY:

Name: _____ Phone #: _____ Relationship _____

FINANCIAL POLICY

Patient's Name _____ **D.O.B.** _____

Primary Insurance Name	Policy Number	Group Number
Subscribers Name	Subscriber's Date of Birth	Subscriber's SSN

Secondary Insurance Name	Policy Number	Group Number
Subscribers Name	Subscriber's Date of Birth	Subscriber's SSN

Party responsible for payment: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other_____

I hereby authorize Bolaji Odusina MD FAAP of Suwanee Pediatrics, PC to apply for benefits on my behalf for covered services rendered and to release medical information to process claims. I request payment from my Insurance Company to be made directly to the above-named provider/ medical office.

I certify that the information I have reported about my insurance is correct and further authorize the release of any necessary information including medical information for this and any release claim, to the above-named billing agent and/or the insurance company.

I also understand that it is my responsibility to update Suwanee Pediatrics, PC with any insurance changes or secondary insurance information to prevent incorrect claim filling.

To properly file your insurance claim(s), we must obtain a current copy of your child's insurance card **each time you visit our office.**

If incorrect or new insurance information is given that requires a claim to be re-filed, there will be a $25 re-filing fee.

- It is your responsibility to contact your insurance company and find out whether our Doctors are participating physicians within your particular insurance plan.
- It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your own insurance policy.
- The following circumstances may result in you being billed directly:
  - We are not participating physicians in your plan
  - Non-covered lab work is order/performed or out of network laboratory
  - Or a non-covered service is performed or denied for the reason "not medically necessary"
- **Co-payments, Deductible and Co-insurance are collected up front and are due at the time of service by the person bringing the patient for the visit. If you do not have your co-pay we will bill you for a $15 administrative fee.**

Name of Parent/ Guardian: _____ Relationship: _____

Signature of Parent/ Guardian: _____ Date: _____ / _____ / 20___

Suwanee Pediatrics
1155 Lawrenceville-Suwanee Rd, Lawrenceville, GA 30043
Phone: (678) 442-0205 | Fax: (678) 442-0185
www.SuwaneePediatrics.com
contact@suwaneepediatrics.com

DISCLOSURE FORM FOR AUTHORIZATION AND COMMUNICATION

Patient's Name _____ **D.O.B.** _____

Please list any persons other than your child's biological parents, members or other persons, if any, who may accompany your child and consent for treatment, and whom we may inform about your child(ren)'s general medical condition or diagnosis (including treatment and healthcare operations). I also give permission for the following persons to make medical decisions in my absence.

The Authorized persons are required to bring a photo ID at the time of service.

I understand that it is my responsibility to revoke this consent in writing for below Authorized Persons.

Name	Phone #	Relationship

We may utilize a **Patient Portal** and/or an **Automated Appointment Reminder** and **Messaging** system to allow us to better serve you. (ex. Appointment reminders via phone and text, online appointment requests, communicate with office via email, online access to your medical information) By providing your cell phone number and email address, we will automatically enroll you in this system(s) if they are available.

I have been made aware of the above disclosure. _____ **Initials**

Name of Parent/ Guardian: _____ Relationship: _____

Signature of Parent/ Guardian: _____ Date: _____ / _____ / 20___

Suwanee Pediatrics

1155 Lawrenceville-Suwanee Rd, Lawrenceville, GA 30043
Phone: (678) 442-0205 | Fax: (678) 442-0185
www.SuwaneePediatrics.com
contact@suwaneepediatrics.com

PATIENT CONSENT FORM

Patient's Name _____ **D.O.B.** _____

I authorize Suwanee Pediatrics to treat my child. I further authorize the release of all medical information necessary for the completion of insurance forms. A photocopy of this authorization shall be considered as effective and valid as original.

I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that if my child's physician or any other person employed by or under the direction and control of my child's physician(s) is directly exposed to any bodily fluid in a manner which may, according to the Center of Disease Control (CDC), transmit HIV, Hepatitis B, or C viruses, that I am deemed by law to have signed consent to testing infection with HIV, Hep B, or Hep C viruses. I further understand that by law, I will have deemed to consent to release the result of the test to the person exposed to my child's body fluid.

Name of Parent/ Guardian: _____ Relationship: _____

Signature of Parent/ Guardian: _____ Date: _____ / _____ / 20___

Suwanee Pediatrics

1155 Lawrenceville-Suwanee Rd, Lawrenceville, GA 30043
Phone: (678) 442-0205 | Fax: (678) 442-0185
www.SuwaneePediatrics.com
contact@suwaneepediatrics.com

Patient's Name _____ **D.O.B.** _____

BIRTH HISTORY

Type of delivery_____ Term _____
Premature at _____ Months _____
Pregnancy number _____ Other _____
Birth wt. _____ Length _____ Discharge wt._____
Apgar score _____ Circumcision _____
Blood type _____ Other _____

FAMILY HISTORY

Mother_____ Age____ Occupation_____
Father_____ Age____ Occupation_____
Siblings_____ Age____ Sex____ Health___
1 _____ 3 _____
2 _____ 4 _____
Other _____

DEVELOPMENT HISTORY (AGE)

Held up head _____
Smiled _____
Sat aided _____
Stood aided _____
Sat alone _____
Reached for objects _____
First teeth _____
Crept _____
Stood alone _____
Walked _____
Said words _____
Sentences _____

High blood pressure _____ Cancer _____
High cholesterol _____ Allergies _____
High triglycerides _____
Do you have pet(s) in your household?
Do your children come in frequent contact with pets or pet surroundings? Yes No

NUTRITION HISTORY

Breast fed _____ Formula _____
Vitamin supplement_____ Type _____
Soft foods added _____
_____
_____

HABITS

Sleep _____ Bedwetting _____
Naps _____ Play _____
School _____ Other _____

Appetite _____
Stools _____
Allergies _____
Other _____

ILLNESS HISTORY

General _____
Allergies _____
Chicken pox _____
Tonsillitis / Pharyngitis _____
Ear infections _____
Asthma / Bronchitis _____
Bronchiolitis / Pneumonia (RSV +/-)_____
Hospitalized _____
Serious injuries _____
Operations _____
Other _____

Suwanee Pediatrics
1155 Lawrenceville-Suwanee Rd, Lawrenceville, GA 30043
Phone: (678) 442-0205 | Fax: (678) 442-0185
www.SuwaneePediatrics.com
contact@suwaneepediatrics.com

DO NOT FAX MEDICAL RECORDS

RELEASE OF MEDICAL RECORDS

By signing this authorization, I authorize *Suwanee Pediatrics, PC* to use and/ or disclose certain protected health information (PHI) about me to or for the party or parties listed below. When requesting medical records, you are agreeing of a $15.00 administrative fee per patient when transferring out. I have the right to revoke this authorization in writing except to the extent that *SUWANEE PEDIATRICS, PC* has acted in reliance upon this authorization. My written revocation must be submitted to *SUWANEE PEDIATRICS, PC* with the address listed above.

Name of Parent/ Guardian: _____ **Relationship:** _____

Signature (Parent/Guardian) _____ **Date:** _____/_____/20_____

The Authorization applies to the following date(s) of service:

☐_____ **to** _____ ☐**Complete Medical Record** *(Historial Medico Completo)*

	Patients Name (Nombre del Paciente)	D.O.B.(Fecha de Nacimento)	Acct #:
1			
2			
3			
4			
5			

Current address: _____ City/State/Zip _____
Direccion *Cuidad / Estado / Codigo Postal*

Primary Phone: _____ Cell: _____ Work: _____
Numero Primario *Celular* *Numero de Trabajo*

Reason for Request to release Medical Records:

☐ Review by Specialist, Surgeon, or Therapist ☐ Moving from Area ☐ Insurance Change
☐ Not able to schedule appointment with provider of your choice
☐ Extended wait times for appointments to physician schedules not being open
☐ Extended wait time scheduling and appointment by phone due to on-hold or busy signal
☐ Extended wait time in waiting and/or exam room
☐ Unsatisfied with the care that was provided
☐ Not satisfied with physician
☐ Unhappy with staff (please specify):_____
☐ Other:_____

☐ Please release records to:
☐ Obtain records from:

Suwanee Pediatrics: Bolaji Odusina M.D., FAAP
1155 Lawrenceville-Suwanee Rd
Lawrenceville, GA 30043
Tel: 678-442-0205 / contact@suwaneepediatrics.com

☐ Please release records to:
☐ Obtain records from:

Name:_____
Address:_____
City/State/Zip:_____
Tel:_____ Fax:_____