MEDICAL HISTORY

Child's Name: _____ DOB: _____

Medications: _____

Allergies (medications, foods, etc.): _____

Are child's immunizations up to date? yes ☐ no ☐

BIRTH HISTORY (only need to complete if child is less than 5 years old)

Hospital where child was born: _____

Birth weight: _____ Discharge weight: _____ vaginal ☐ C-section ☐

Gestational age (weeks old at birth): _____ Reason for C/S (if applicable): _____

Hep B given? yes ☐ no ☐ Hearing screen passed? yes ☐ no ☐

Mom's pregnancy health: _____

Complications with infant: _____

NICU? yes ☐ no ☐ _____

PAST MEDICAL HISTORY

Hospitalizations: _____

Surgeries: _____

ADHD/ADD	☐	Cancer (list type)	☐	Kidney Disease	☐
Allergies	☐	Cerebral Palsy	☐	Learning Disability	☐
Anemia	☐	Diabetes	☐	Migraines	☐
Asthma	☐	Eczema	☐	Seizures	☐
Autism	☐	Freq. Ear Infections	☐	Sickle Cell Disease	☐
Bronchiolitis	☐	Heart Defect	☐	Urinary Tract Infections	☐

Other: _____

MEDICAL HISTORY

FAMILY HISTORY (note F - father, M - mother, S - sibling, GF - grandfather, GM - grandmother)

ADHD/ADD _____	Depression _____	Migraines _____
Allergies _____	Diabetes _____	Seizures _____
Anemia _____ (not iron related)	Heart Attack _____ (list age of occurrence)	Sickle Cell Disease _____
Asthma _____	High Blood Pressure _____	Sickle Cell Trait _____
Autism _____	High Cholesterol _____	Stroke _____ (list age of occurrence)
Bleeding Disorder _____	Kidney Disease _____	Sudden Cardiac Death _____ (list age of occurrence)
Cancer (list type) _____	Mental Illness _____	Thyroid Disease _____

Other: _____

SOCIAL HISTORY

Household Members: _____

Who is primary caretaker(s) or has custody of child: _____

Childcare: Attends school/preschool ☐ Attends daycare ☐ Stays home ☐

Pets Yes ☐ No ☐

Smokers (including outside) Yes ☐ No ☐

Comments: _____

HOW DID YOU HEAR ABOUT COBB PEDIATRIC ASSOCIATES?

From a friend (word of mouth) ☐	Google ☐
Insurance Company ☐	Another doctor (OB/GYN) ☐
Facebook ☐	Other _____

Patient Registration Form

COBB PEDIATRIC ASSOCIATES, P.C.

PATIENT'S NAME: _____

(Parents)	*Mother/Parent 1*	*Father/Parent 2*
Full Name		
Date of Birth		
Marital Status		
Home Address, Street		
City, State, Zip		
Home or Primary Phone		
Cell Phone No.		
Work Phone No.		
E-mail Address		
Employer Name		
Employer Address, Street		
City, State, Zip		
Nearest Relative and Phone No. (home & cell)		

Child's Information	
Date of Birth	
Gender	
Race	
Ethnicity	
Preferred Language	
Name *all siblings seen by our providers*	

INSURANCE	*Primary*	*Secondary*
Subscriber		
Company		
Address **City, State, Zip**		
Policy Number		
Group Number		

***Please let us know who referred you to our office, as we would like to say thank you*. _____**

_____

I, _____, have received a copy of Cobb Pediatric Associates, P.C.'s Notice of Privacy Practices, Financial Policy, Appointment Cancellation Policy and the Statement Regarding Cobb Pediatric Associates' Use of Nurse Practitioners as Medical Providers in the Practice. ***I understand that I have the right to refuse to complete and to sign this form; however, by doing so, I am required to pay for services to Cobb Pediatric Associates, PC, in full, at the time of service.***

***Signature:** _____ **Date:** _____

(Guarantor)

Denise Nakos, MD • Beatrice Wilder, MD • Charles C. Richards, MD
Noureen Husain, MD • Pooja Chandra, MD • Yvonne Ibe, MD

Dear Parents:

Congratulations on the birth of your new baby! You are now beginning a very rewarding chapter of your life – Parenthood. Cobb Pediatric Associates has been a part of the Cobb County Health Community for over 32 years with a dedication to provide quality medical care for your infants, children, and adolescents. Children are our future and it is our goal to maintain a friendly, professional and responsive relationship with you to better serve your family's medical needs.

We ask parents of newborns to assist us in the registration process with their insurance information prior to the baby's first visit. Your baby's first office visit can be overwhelming with the many things new parents must remember (not to mention while being sleep deprived). We are your child's health care provider first, and his/her health remains our number one concern. However; we are in business, with employees and overhead that must be met. Your help in the registration-eligibility process will insure fewer mistakes with the original claim and a quicker response from your insurance carrier, which helps to establish a good base in our relationship for the future.

If you would like for us to bill your insurance company, please fill out the information all of the forms in this packet, and give to our Insurance Representative at the time of your visit, or mail to the office. Prior to coming to our office, you may wish to review our office policies, including our policy regarding childhood vaccines. Please remember, if we are unable to file your insurance claim, you will be required to pay your balance at the time of service. Your cooperation in this matter is appreciated.

Sincerely,

Cobb Pediatric Associates, P.C.

1060 Windy Hill Rd, Suite 200, Smyrna, GA 30080 770-941-7709

FINANCIAL POLICY

There have been numerous changes in health care in the past few years, making it more difficult for us to receive payment for the services that we provide. Therefore, the following is a list of guidelines that are necessary for us to enforce in order to continue to provide high quality care and make your visit as pleasant as possible. **PLEASE READ ALL INFORMATION AND SIGN YOUR ACKNOWLEDGEMENT OF READING THIS POLICY IN BOTH AREAS INDICATED ON THE FOLLOWING PAGE.**

1. We will collect your co-pay, deductible, uncovered services or percent responsibility at the time of your visit. A $25.00 service fee will be charged to you should you fail to pay your copay at the time of service.

2. Please be very thorough in giving us your insurance information if you wish us to file your claims on your behalf. Always bring your current insurance card and any authorization needed that you may have. You will be responsible for any unpaid balances due to lack of information.

3. We will file your insurance claims for you. It is your responsibility to make sure we receive prompt payment from them (within 30-45 days is usual). It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as they should.

4. Your insurance company will send you an Explanation of Benefits (EOB) that explains what they have paid to our office. This is a record that you must keep on file. If you do not agree with their payment, please contact the insurance company.

5. During the well visit, the physician may discover a “condition” or illness that requires diagnosis, treatment or follow-up. Charges for this will be covered as an illness visit by insurance, which may require a copay or co-insurance or deductible to you. Determination of any patient responsibility comes from the insurance company according to your policy benefits.

6. If your insurance denies payment for any reason, you will be asked to pay by check, cash, and money order, Visa, MasterCard, Discover or American Express. If you do not pay in a timely fashion, your account will be placed into collections with our collection agency, Diversified Accounts Systems, Morrow, Georgia.

7. SELF-PAY PATIENTS: This category includes those people with no insurance and those patients who have an indemnity plan and wish to file their own insurance. To assist those patients with no insurance, our office will apply a 10% (ten percent) discount toward the office visit charge, excluding any laboratory fees, injections, etc. To qualify for this discount, you must make payment in full on the date of service. Due to the cost of maintaining and billing your account, we cannot apply this discount once you have left the office.

Payment for medical services is expected before the service is rendered. We accept cash, check, money order, Visa, Mastercard, Discover, and American Express. If you will not be able to pay for

services in full at the time of service, you must make payment arrangements prior to coming to see the provider. If you have no prior agreement with our office, payment in full paid in advance, will be expected. If payment is not possible, we may re-schedule the visit.

8. If your insurance is out of state (except for PPO insurance), you must pay for your visit at the time of service. Most out of state plans pay the patient and will not pay us directly (even if they tell you they will). Payment will be collected up front in full and we will provide you with all the appropriate information to file the claim yourself.

9. It is your responsibility to know what your insurance will or will not pay. You must let the doctor/nurse practitioner know if your insurance company will not pay for routine or well visits, laboratory tests, injections, etc. Our providers will make every effort to work with your insurance requirements; however, we will code your claim/claims according to the diagnosis as determined by the provider.

10. Because of the nature of our specialty, we try to maintain an even patient flow when scheduling. In the event you cannot keep your appointment, you must call our office within twenty four (24) hours of your appointment time. Please see additional handout regarding this policy in detail.

FOR YOUR INFORMATION:

Our practice's policy is to file claims to insurance companies electronically the morning of the next business day following the date of service.

Remember you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, and not this practice. Please do not hesitate to contact them if you disagree with their payment or find out the status of our claims.

If you have any questions regarding our financial policy, please state your questions prior to being seen in the office. You may call (770) 941-7709 to discuss our financial policies.

_____ _____

Parent or Guardian Signature Date

Note: Our participation with your insurance does not guarantee their payment of your bill.

Patient Agreement for Communications

I _____, understand that as part of the heart care of my child/children listed below

_____ _____

_____ _____

Cobb Pediatric Associates, PC will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow, etc. I hereby authorize *Cobb Pediatric Associates, PC* to contact me in the following ways:

(Check all that apply and provide numbers/e-mail addresses)

___ Home Phone:_____Leave voice mail?__yes__no
___ Mobile Phone:_____Leave voice mail?__yes__no
___ Office Phone:_____Leave voice mail?__yes__no
___ E-mail Address:_____
___ Fax:_____

My child's condition and medical information may be discussed with the following person(s) on my behalf:

1. Name/Relationship_____
2. Name/Relationship_____
3. Name/Relationship_____

I understand that *Cobb Pediatric Associates, PC* will use the minimum necessary information needed when communicating indirectly. I understand that I have the right to revoke or amend this agreement at any time. Any revocation or change will not apply to any communications already completed. I understand that *Cobb Pediatric Associates, PC* will not share this information with any third party vendors or parties at any time.

_____

Parent/Guardian's Signature Date

Denise Nakos, MD • Beatrice Wilder, MD • Charles C. Richards, MD
Noureen Husain, MD • Pooja Chandra, MD • Yvonne Ibe, MD

PERMISSION TO SEND PATIENT HEALTH INFORMATION (PHI)

BY UNENCRYPTED EMAIL

Per 2023 guidelines of the US Department of Health and Human Services all individuals have a right to receive a copy of their Patient Health Information (PHI) by unencrypted e-mail, if the individual requests access in this manner. In such cases, there is some level of risk that the individual's Patient Health Information (PHI) could be read or otherwise accessed by a third party while in transit. The practice will not be held liable for breach or disclosures of such information that might occur in transit. Further, the practice is not responsible for safeguarding the information once delivered to the individual.

By signing below, I confirm that I fully understand the risks of sending Patient Health Information by unsecured email and request to receive the PHI by unencrypted e-mail.

_____ _____

SIGNATURE Parent/Guardian of Patient Date

_____

PRINT Parent/Guardian of Patient

1060 Windy Hill Rd, Suite 200, Smyrna, GA 30080
(770)941-7709 www.cobbpedassoc.com