FamilyWellnessMD
Healthy Families. Healthy Kids.

Medical History Form

Patient Name:_____ **Date of Birth:**_____ ☐M ☐F

Birth History

Birth Hospital_____
☐ Vaginal ☐ Cesarian
☐ Forceps ☐ Vacuum

☐ Fullterm ☐ Preterm

Weight _____Length_____
Prenatal complications:_____
_____
Newborn complications_____
_____
_____

Social History

Parents:
☐ Married ☐ Single
☐ Separated ☐ Child Adopted
Siblings:
☐ Brother(s)___ ☐ Sister(s)___

Smoking in home:
☐ Yes ☐No

Pets in home:
☐ Yes. ☐ No
Type of animal_____

Allergies

☐ No ☐ Yes, please list
_____
_____

Medications/Supplements

☐ No ☐ Yes. Please list
_____
_____
_____
_____
_____

Hospitalizations:

_____**Date**_____
_____**Date**_____

Surgeries:

_____**Date**_____
_____**Date**_____

Family History:

Please list any medial problems in the family members listed below

Father_____**Grandfather**_____**Grandmother**_____
Mother_____**Grandfather**_____**Grandmother**_____
Siblings: Sister_____**Brother**_____

Parent signature_____**Date**_____

Reviewed by_____**Date**_____

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Family Wellness MD Notice of Privacy Practices
Acknowledgement and Patient Consent for Use and Disclosure of PHI

Family Wellness MD
3371 N. Berkeley Lake Rd NW Suite 101
Berkeley Lake, GA 30096

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my (my child's) protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my (child's) 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 have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my (child's) health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

With my consent, Family Wellness MD may contact me via (check all that apply):
____telephone
____email
____text
____Electronic Medical Records portal
In reference to any items that assist the practice in carrying out patient care related items such as appointment reminders, insurance items and items pertaining to my child's clinical care including laboratory results among other items. I also understand that my child's provider may access my child's previous medical history from other medical institutions through CareQuality or CommonWealth interfaces in the EMR.

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 health care 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.

Patient Name_____DOB_____
Parent Signature _____Date_____
Print Name _____
Relationship to Patient _____

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Patient Intake Form

Patient Information

Name of Patient_____Date of Birth_____
Race_____Ethnicity_____ ___Male ___Female
Preferred Language_____

Address_____
City_____State_____Zip_____
Phone number (H)_____ (C)_____
Email Address_____

Mother of Patient Name_____Date of Birth_____
Father of Patient Name_____ Date of Birth_____

Emergency Contact Information

Emergency Contact Name_____
Emergency Contact Phone Number_____
Relationship to patient_____

Insurance Information

Primary Insurance

Insurance Carrier_____Insurance Plan_____
Policy Number_____Group Number_____
Insurance Carrier Contact Number_____
Guarantor's Name_____Date of Birth_____
Address of Guarantor_____
Phone Number of Guarantor_____

Secondary Insurance

Insurance Carrier_____Insurance Plan_____
Policy Number_____Group Number_____
Social Security Number of Gaurantor_____
Insurance Carrier Contact Number_____
Financial Services, Treatment Policies and Procedures Consent Agreement

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Family Wellness MD Financial Services, Treatment Policies and Procedures Consent Agreement

Patient Name_____DOB_____

Family Wellness MD is committed to meeting your child's health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this, we ask that you adhere to the following guidelines.

- Your current address, telephone number and insurance information may be verified at each visit and should be updated in the patient portal in our electronic medical system. You will have the option to allow for email or text correspondence to receive information about upcoming appointments with our electronic medical system.
- If your managed care plan requires a PCP (Primary Care Physician) a provider at Family Wellness MD will need to be listed as your child's PCP in order for your child to be seen in our office.
- All Co-payments are due at the time of service, as per our contract with your insurance carrier. Most insurance policies now have a deductible and/or coinsurance, which may be in addition to your copay. In general, most policies now cover preventative health visits without a co-pay, coinsurance or deductible, however, many insurances do not cover other significant concerns that may be addressed during the health visit. Your insurance company may require you to cover the cost of the co-pay for the addition concerns (ear infection, ADHD, asthma, etc).
- You will be financially responsible for any charges not covered by your insurance carrier for services provided. By signing below you understand that GIM Enterprises LLC will send medical record information to your insurance company to obtain payment for services rendered.
- Attempts will made to contact you to confirm your child's appointment. We request 24 hour notice for cancellation of appointments scheduled. A $25 fee may be assessed for appointments that are not cancelled in the requested time.
- All medical record requests must be done in writing and received in our office 7-10 days prior to the date needed. A $20 fee will be assessed for a copy of medical records requested.
- By signing below, you authorize and voluntarily consent to medical care by GIM Enterprises LLC doing business as Family Wellness MD (the practice) and its employees to obtain your child's medical record and to provide your child with basic comprehensive medical care, treatments and procedures as recommended by your child's provider in the course and the scope of services provided by this pediatric medical practice. Although vaccines may be recommended in the care of your child, if declined by you, no medical exemptions will be provided. You also understand that you have the right to refuse any treatment.

Parent/Guardian Signature _____ Date_____

Print Name _____

Relationship to Patient _____