South Georgia Pediatric & Allergy Center, P.C.

3440 N. Valdosta Road
Valdosta, Georgia 31602
Phone: 229.247.2211 Fax: 229.249.9490

NEW PATIENT REGISTRATION PACKET

Thank you!

We would like to extend to you a warm welcome to South Georgia Pediatric & Allergy Center, P.C. We are elated that you have chosen us and we are confident that you will be pleased with the service and care we provide.

We need you to know that as of 7/1/19, in order to best protect our patients and due to the risks of exposure, South Georgia Pediatric and Allergy Center, P.C., will ***no longer accept new unvaccinated patients or patients who are planning not to vaccinate in accordance with the requirements and recommendations by the American Academy of Pediatrics***. We are in agreement with all the board certified pediatricians in our community, that vaccinating children is in the best interest of their health.

As part of patient registration process, we ask that you complete the entire new patient packet for each child. If forms are not completed, patient review and approval may be delayed or denied. Review and approval process may take up to one week or longer. Primary guardian will be notified once accepted and medical record release has been processed.

OFFICE HOURS

Monday – Thursday: 8:15 a.m. - 4:30 p.m.
Friday: 8:15 a.m. - 12:00 p.m.

Office begins taking calls at 8:30 a.m.
Allergy shots begin at 8:30 a.m.
We accept walk-ins office visits. Please call our office to check daily availabilities.

After Hours Pediatric Walk-In Clinic

Subject to availability. Please call for correct openings.

Monday-Thursday: 5:30-8:00 P.M. • Friday: 1:00-4:30 P.M.

Saturday & Sunday: 10:00 A.M. – 4:00 P.M.

Doors are locked promptly at closing times and/or by provider discretion.

After Hours Phone Triage Nurse: 229.560.3216

Our nursing staff provides an after-hours nurse to take non-emergent calls for questions and concerns regarding our patients. **Monday-Thursday nightly beginning at 6:00 p.m. – 7:00 a.m. the next morning Fridays begin at 2:00 p.m. until Monday at 7:00 a.m.**

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NEW PEDIATRIC PATIENT REGISTRATION FORM

LEGAL LAST NAME_____LEGAL FIRST NAME_____ MI_____

DOB_____ SEX: M OR F SOCIAL SECURITY#_____

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER_____

RACE:_____ ETHNICITY: HISPANIC NON-HISPANIC OTHER

PATIENT LIVES WITH: MOTHER FATHER BOTH OTHER: _____

Guarantor & Contact Information

PRIMARY GUARADIAN: _____ RELATIONSHIP:_____

DOB: _____ SS#:_____ EMPLOYER:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

PRIMARY PHONE:_____ SECONDARY PHONE:_____

E-MAIL ADDRESS:_____

SECONDARY GUARDIAN: _____RELATIONSHIP:_____

DOB: _____ SS#:_____ EMPLOYER:_____

ADDRESS: _____CITY:_____STATE:_____ ZIP:_____

PRIMARY PHONE:_____ SECONDARY PHONE:_____

Insurance Information– (Provide a copy of your Insurance Card)

PRIMARY INSURANCE_____ ID#_____

SUBSCRIBER_____DOB:_____ SS#_____

SECONDARY INSURANCE _____ ID#_____

SUBSCRIBER_____DOB:_____ SS#_____

PREVIOUS PROVIDER:_____

REASON FOR TRANSFER:_____

CURRENT/PREVIOUS DIAGNOSIS: 1._____ 2._____

3._____ 4._____ 5._____

CURRENT/PREVIOUS MEDICATIONS: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

IS PATIENT VACCINATED OR PLANNING TO VACCINATE? YES NO *We do not accept patients who refuse vaccines – this currently does not include COVID or Influenza vaccines.*

Signature_____Date_____

In Office only:
Dr. Alan Alvarado Dr. Robert Criscuola

Accepted_____ Declined_____

PA#_____

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NOTICE OF PRIVACY PRACTICES (HIPAA) & AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Notice of Privacy Practice informs how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also defines your rights to access and control your protected health information.

Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to obtain payment for your health care bills, to support the operation of the physician's practice, and any other use as required by law. For proper treatment, your PHI may be disclosed to a third party including referred physicians and home health agencies. In supporting business operations, your PHI may be disclosed to Public Health, Public Safety, Communicable Diseases, Health Oversight, Food and Drug Administration, Abuse or Neglect, Law Enforcement, Legal Proceedings, Coroners, Funeral Directors, Organ or Tissue Donation Agencies, Research, Worker's Compensation, and other uses as required by law.

You have the ability to revoke the authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to request a restriction of your PHI as well as the right to authorize disclosure of your PHI.

Therefore, I, _____, hereby authorize South Georgia Pediatric and Allergy Center, P.C. to communicate with and disclose my or my child's PHI to the following person(s):

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

OR

I request that my or my child's PHI to only be disclosed to me._____

(Signature)

***Please note: if you are requesting that a child's biological parent NOT have access to their medical records you must provide court documentation supporting this request.*

Patient Name:_____DOB:_____

Guarantor Signature:_____Date:_____

This disclosure will remain in effect until I give written notification otherwise.

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OFFICE POLICES, FORMS & FEES

PATIENT'S NAME:_____DOB:_____

****Please initial for acknowledgement of each policy.****

_____ At each visit a sign-in label will be require completion for each patient. This includes current address and phone number of guardian and requests the person's name accompanying the patient, if applicable.

_____ All patients must be accompanied by a parent/guardian of at least 18 years of age. If patient(s) are more than fifteen (15) minutes late for a scheduled appointment, you may be asked to reschedule or be given the option of being seen as a same day walk-in. After **three (3) or more missed appointments** in a **twelve (12) month period**, patients **may be subject to dismissal from SGPAC.**

_____All Allergy/Immunology/Asthma patients must give at least twenty-four (24) hours notice for rescheduling. All missed allergy/immunology/asthma appointments may be subject to a **$25 no-show fee** and must be paid in full before patient can be seen in the office. After **two (2) missed appointments**, patients **may be subject to dismissal.**

_____Electronic devices, including cell phones, are not permitted during patient triage or in exam rooms with nurses or providers, this includes videoing. **Failure to adhere to this policy may delay visit or result in dismissal.**

_____All copays, deductibles and balances are due at the time of service(s) rendered. If accounts have a balance due and arrangements have not been made or agreements not honored your appointment may be rescheduled. Divorce, separation or custodial decrees will not exempt authorizing guarantor from payment collection at time of rendered services.

_____Updated insurance information must be provided prior to patient visits. Any discrepancies with insurance claim coverage must be handled by insurance subscriber with the insurance company. Any non-covered services will be the guarantor's responsibility and must be paid within ninety (90) days or will result in additional collection fees.

_____Please allow 24-48 hours for all shot record, sports physical, and vision, hearing, dental, and nutrition form (EED) requests to be completed and allow up to five (5) business days for all school/ college forms, PCS forms, camp forms, family medical leave forms, and letters to be completed.

_____All patients being treated for ADD or ADHD must be seen one (1) month after initial diagnosis and treatment or medication change for medication refills and every two (2) months subsequently for refills.

_____ All patients must be vaccinated or planning to vaccinate. Patients whose parents choose not to vaccinate will not be accepted because our providers, like all board certified pediatricians in our community, believe vaccinations are in the best interest of children and their health. Copies of vaccination information sheets are available upon request.

_____ In the event of an emergency and guarantor/authorized persons cannot be reached; I give permission for my child to be treated by SGPAC staff as required by events of that emergency.

_____I have read and understand all office policies and procedures of SGPAC and am able to receive a copy if requested.

_____ _____

Guarantor Signature **Date**

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Alan J. Alvarado, M.D.
Board Certified Pediatrics
Board Certified Allergy and Immunology

Robert J. Criscuola, M.D.
Board Certified Pediatrics

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____
PRINT PATIENT'S NAME PATIENT'S DATE OF BIRTH

_____ _____
PRINT NAME OF PARENT/LEGAL GUARDIAN PHONE NUMBER

Previous Provider Practice & Name: _____

Address:_____ City, State: _____Zip:_____

Phone:_____ Fax: _____

Check One:

I am the _____Patient (if 18 or older)
_____Parent
_____Legal Guardian with custody

Records to be Released:

_____All records including immunization records
_____:Other: _____

Purpose of Release of Protected Health Information is:

_____Transferring Physicians
_____Continued Medical Care
_____Legal Action/Review
_____Other:_____

This Authorization expires in 6 months (12 months for school requests) unless otherwise disclosed: _____

Mail Paper Copy/Disc or Fax Records to:
South Georgia Pediatric and Allergy Center, P.C.
3440 North Valdosta Road
Valdosta, Georgia 31602
Fax: 229.249.9490

- I place no limitations on history of illness (including HIV and/or AIDS, genetic, drug dependency psychiatric information) or diagnostic and therapeutic information (including treatment for alcohol/drug abuse or psychiatric disorders).
- I authorize the inspection of the above information by the above named agency.
- I understand that unless otherwise limited by state or federal regulations, I may withdraw this consent at any time by submitting my withdrawal request in writing.
- I hereby acknowledge that I have read or have had read to me the above statements, and I fully understand and do expressly and voluntarily authorize the disclosure of medial information to the agency listed above.

Guarantor: _____ Date:_____

SGPAC Witness: _____ Date:_____

South Georgia Pediatric & Allergy, P.C.

PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date:	Child's Name:	DOB:	M F
Previous Physician:		Date of Last well visit:	
Mother's Full Name:		Father's Full Name:	
Step-Mother's Name (if applicable):		Step-Father's Name (if applicable):	
Guardian's Full Name:(if different from above):		Relationship to Patient:	

Birth History

Birth Weight :_____ Hospital:_____ Mom's Age:_____ Was the birth: Vaginal Cesarean Early Late

If birth was early, how many weeks early?_____ If Cesarean, why?_____

Did mother have any illnesses/problems with her pregnancy? Yes No Explain:_____

Did baby have jaundice: Yes No Bili Level:_____ Was initial feeding: Breast Formula_____

Before mother knew she was pregnant or at any time during her pregnancy did she:

Yes No Smoke Cigarettes (amount)_____ Yes No Drink Alcohol (amount)_____

Yes No Use "street" drugs (type)_____ Yes No Use Prescription Drugs (type)_____

Birth Complications:_____ Neonatal Problems:_____

Current and Past History

Is your child currently on any medication?	Yes	No	Explain:_____
Does your child have any serious or chronic Illnesses?	Yes	No	Explain:_____
Has your child had serious injuries or accidents?	Yes	No	Explain:_____
Has your child had any surgeries?	Yes	No	Explain:_____
Has your child ever been hospitalized?	Yes	No	Explain:_____
Is your child allergic to any medications?	Yes	No	Explain:_____
Has your child ever reacted to immunizations?	Yes	No	Explain:_____
Does your child drink any caffeine?	Yes	No	Explain:_____

Does Your Child Have or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	Yes	No	Explain:_____
Nasal allergies or eczema	Yes	No	Explain:_____
Frequent ear infections or sore throat	Yes	No	Explain:_____
Problems with ears or hearing	Yes	No	Explain:_____
Problems with eyes, vision or teeth	Yes	No	Explain:_____
Frequent headaches or other neurologic problems	Yes	No	Explain:_____
Frequent abdominal pain	Yes	No	Explain:_____
Constipation requiring doctor visits	Yes	No	Explain:_____
Bladder/kidney problems or bedwetting	Yes	No	Explain:_____
Any heart problems/murmur	Yes	No	Explain:_____
Anemia or bleeding problems	Yes	No	Explain:_____
Thyroid or other gland problem	Yes	No	Explain:_____
Diabetes	Yes	No	Explain:_____
ADHD/ADD	Yes	No	Explain:_____
Mental Health Issues	Yes	No	Explain:_____
Use of drugs or alcohol	Yes	No	Explain:_____
History of emotional trauma/sexual abuse	Yes	No	Explain:_____

Please Complete Back of Form

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Are there siblings not listed above? Please list their full names and ages and where they live.

Child Care: _____

School and Grade: _____

Smokers in household? Yes No

Pets? Yes No

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	Yes	No	Who_____	Comments_____
Allergies	Yes	No	Who_____	Comments_____
Asthma	Yes	No	Who_____	Comments_____
Birth Defects	Yes	No	Who_____	Comments_____
Blood Disorders	Yes	No	Who_____	Comments_____
Bone Disorders	Yes	No	Who_____	Comments_____
Cancer	Yes	No	Who_____	Comments_____
Diabetes	Yes	No	Who_____	Comments_____
Endocrine Disease	Yes	No	Who_____	Comments_____
Ear/Nose/Throat	Yes	No	Who_____	Comments_____
Disorders	Yes	No	Who_____	Comments_____
Eye Disorders	Yes	No	Who_____	Comments_____
Gastrointestinal Disorders	Yes	No	Who_____	Comments_____
Heart Disease	Yes	No	Who_____	Comments_____
High Blood Pressure	Yes	No	Who_____	Comments_____
High Cholesterol	Yes	No	Who_____	Comments_____
Immune Disorders	Yes	No	Who_____	Comments_____
Joint Problems	Yes	No	Who_____	Comments_____
Kidney Disease	Yes	No	Who_____	Comments_____
Liver Disease	Yes	No	Who_____	Comments_____
Lung Disease	Yes	No	Who_____	Comments_____
Migraine Headaches	Yes	No	Who_____	Comments_____
Metabolic Disorders	Yes	No	Who_____	Comments_____
Obesity	Yes	No	Who_____	Comments_____
Seizure Disorders	Yes	No	Who_____	Comments_____
Skin Disorders	Yes	No	Who_____	Comments_____
Stroke History	Yes	No	Who_____	Comments_____
Thyroid Disorder	Yes	No	Who_____	Comments_____
Mental Health History	Yes	No	Who_____	Comments_____