



****In the case of treating Foster Children, either a Judge or DFCS Agency of the county that has custody of the child, is the only person/entity that has the right to consent to healthcare treatment for the foster child in state custody. In the event that a foster child comes into the practice to be seen, without written consent provided on the State of GA/AL/FL letterhead, that include the Judges Signature and/or Case Workers Signature and the person's name that brought the child in, the child will not be seen. If the child has two foster parents, both "MUST" be listed on the document as well.

New Patient Registration Form

Date: _____

Patient Name: _____
 Address: _____

DOB: _____
 City: _____ State: _____ Zip: _____
 Sex: M F SSN _____

Race/Ethnicity

 American Indian / Alaska Native Asian African American/Black Caucasian/White
 Hispanic Native Hawaiian / Other Pacific Islander Other

Primary Language: _____

Primary Contact Number: () _____ - _____ Secondary Contact Number: () _____ - _____

Previous PCP: _____

PCP Phone: () _____ - _____ PCP Fax: () _____ - _____

How did you hear about us: (please check one)

Friends / Family Magazine Web Other _____

Mother's Name _____
 SSN _____ DOB _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Work Phone _____
 Employer _____

Father's Name _____
 SSN _____ DOB _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Work Phone _____
 Employer _____

Emergency Contact _____
Phone () _____ - _____
Relationship to Patient _____

Pharmacy Information

Pharmacy Name: _____ Location: _____

PATIENT PORTAL COMMUNICATION

Use of Electronic Communication from ZÖe Pediatrics to the Patient

YES, I want ZÖe Pediatrics to communicate my child(ren)'s information with me through a secure patient portal system that is designed to keep medical information safe. You will be notified by email when there is secure information for you to review. The email will provide a link that will take you to your patient portal. After clicking the link, you will be required to log in and enter a password to access your information. You will need to make note of the password to access any future information.

*** Please enter in the space below the email address you would like to use to be notified of secure messages ***

Email Address (please print clearly)

In choosing your email address, please consider the privacy implications. For example, any other person that may have access to your email address, such as an employer, may have the right and/or ability to review any email you receive.

NO, I do not want ZÖe Pediatrics to use electronic communication as a way to communicate my child(ren)'s information to me. I understand that copies of lab results, physician statements, and shot records I request to be printed, faxed, and/or mailed may incur a fee.



Please list all children living in the child's home

Name	Relationship to Patient	Date of Birth

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Holder Name _____	Policy Holder Name _____
Insurance Company _____	Insurance Company _____
Address _____	Address _____
Phone () ____ - _____	Phone () ____ - _____
Effective Date ____/____/____	Effective Date ____/____/____
Subscriber # _____	Subscriber # _____
Group # _____	Group # _____

Financial Responsibility for Services Rendered by ZÖe Pediatrics Physicians

I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been processed and paid. I further understand that if my claim is not accepted for payment. I am personally responsible for payment of medical services rendered to myself or a member of my family.

I acknowledge that medical billing statements for services rendered by ZÖe Pediatrics Physicians will be sent to the person who carries the insurance for the patient/family member.

- I understand that I am responsible for the accuracy of the information I have provided on this form.
- I authorize payment of medical benefits to be made directly to ZÖe Pediatrics.
- I authorize the release of medical records necessary to process insurance claims.
- I authorize the release of correspondence and/or medical records to payers involved in my child's care.
- I have read and understand the Financial Policy.

 (Print name) (signature) (date)

Self Parent Legal Guardian *(Please Select One)*

LATE TO APPOINTMENT POLICY

We value your time and strive to see you as close to your appointment time as possible. Recognizing unanticipated things happen, we will hold your appointment for a 15-minute grace period after the scheduled start time of your appointment. In consideration of every patient, all appointments will be automatically canceled thereafter. If you arrive after your appointment has been cancelled, you will be asked to either reschedule the appointment or wait to be seen as a 'Walk-In' patient.

PATIENT MEDICAL HISTORY

LAST _____ FIRST _____ MIDDLE _____

PREVIOUS/PREFERRED NAME: _____

DOB _____ AGE _____ MALE _____ FEMALE _____

TODAYS DATE: _____

NEW PATIENT ESTABLISHED PATIENT

Person completing this form: _____

Relationship to patient: _____

GENDER IDENTITY (IF APPLICABLE) _____

GENERAL MEDICAL INFORMATION

PRESENT HEALTH CONDITIONS

ALLERGIES (MEDICATION/FOOD)

DENTIST: _____

SPECIALIST CURRENTLY TREATING:

PAST MEDICAL HISTORY

___ ASTHMA CONCUSSION

___ ADHD BIRTH DEFECTS

___ EYEGASSES ALLERGIES

___ HEARING LOSS BROKEN BONE(S)

___ VISION PROBLEMS OT/PT THERAPY

___ AUTISM EPILEPSY

HOSPITALIZATION / SURGERY ___Y ___N

___ EAR TUBES ___ TONSILLECTOMY ___ ADENOIDS

BIRTH HISTORY / DEVELOPMENT HISTORY

BIRTHPLACE / HOSPITAL: _____

PREMATURE: ___Y ___N

___ VAGINAL ___ C-SECTION

HISTORY OF DEVELOPMENTAL DELAY ___Y ___N

FAMILY HISTORY

Is the Patient Adopted or In Foster Care? ___Y ___N

Any history in close relative: (please check all applicable)

PARENT(S), GRANDPARENT(S), SIBLING(S)

___ ASTHMA CONCUSSION

___ ADHD BIRTH DEFECTS

___ EYEGASSES ALLERGIES

___ HEARING LOSS BROKEN BONE(S)

___ VISION PROBLEMS OT/PT THERAPY

___ AUTISM EPILEPSY

___ MENTAL HEALTH HEART DISEASE

___ AUTOIMMUNE DISORDER HYPERTENSION

___ OTHER

SOCIAL HISTORY

PARENTS

MARRIED ___ LIVING TOGETHER ___

SEPARATED / DIVORCED ___

IF SCHOOL AGE, WHAT GRADE? _____

DAYCARE/ AFTERSCHOOL PROGRAM? ___Y ___N ___

HEALTH RISK

EXPOSED TO TOBACCO ___Y ___N

PETS IN THE HOME ___Y ___N

LEAD EXPOSURE ___Y ___N

GUNS IN THE HOME ___Y ___N