CHILDREN'S HEART SPECIALISTS OF GEORGIA
PATIENT DEMOGRAPHIC INFORMATION

Name _____ DOB_____ AGE_____ Today's Date_____

Mothers' Name _____ Fathers' Name _____

Mother's Social Security #:_____ Father Social Security#:_____

Address: _____

_____

Mother's DOB:_____ Father's DOB_____

Mother's Home Phone: _____Father's Home Phone:_____

Mother's Cell Phone: _____Father's Cell Phone: _____

Mother's Employer: _____ Father Employer: _____

Mother's Work Phone: _____Father's Work Phone _____

E-Mail Address (This email address will be used for the patient portal)_____

Name of your pediatrician / primary care provider:_____

Name and address of your pharmacy:_____

_____

Marital Status of Parents: Single_____ Married _____ Widowed_____ Divorced_____

Number of children living in the house_____

IN CASE OF EMERGENCY CONTACT: _____

Name **Phone#** **Relationship**

ALL CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS IN-PATIENT HOSPITAL SERVICES

I hereby authorize the above physician to obtain records from other sources as may be needed in the treatment of this patient.
I hereby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatment of this patient.
I hereby authorize the release of information to the insurance company as needed to pay for charges incurred by this patient.
I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital.
I understand that I am responsible for any amount not covered by the insurance company.

A copy of this information shall be as valid as the original.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Patient's Name Print Name of Patient or Legal Guardian

CHILDREN'S HEART SPECIALISTS OF GEORGIA
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, Children's Heart Specialists of Georgia may use and disclose protected health information (PHI) about me or my child to carryout treatment, payment and healthcare operations (TPO). Please refer to Children's Heart Specialists of Georgia's notice of privacy practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Children's Heart Specialists of Georgia reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of privacy Practices may be obtained by forwarding a written request to Children's Heart Specialists of Georgia, Privacy Officer at 3040 Highlands Parkway, Suite D, Smyrna, Georgia 30082.

With my consent, Children's Heart Specialists of Georgia may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to me or my child clinical care, including laboratory results among others.

With my consent, Children's Heart Specialists of Georgia may mail to my home or other designates location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Children's Heart Specialists of Georgia may email my appointment reminder cards and patient statements. I have the right to request that Children's Heart Specialists of Georgia restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Children's Heart Specialists of Georgia's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, Children's Heart Specialists of Georgia may decline to provide treatment to me or my child.

I understand that Children's Heart Specialists of Georgia participates in Tanner Health's Community Connect Program and that patient data will be stored in a shared community electronic record. My clinical data or my child data may be shared with Tanner Health, its affiliates, and other healthcare providers who are associated with my medical care or my child medical care.

I understand that this practice also participates in a secure Health Information Exchange (HIE). The HIE supports integrated system patient care initiative by allowing physicians and healthcare providers to share and access patients' health information through an HIE for treatment, payment, and healthcare operations purposes. I understand that I have a right to opt out of having my information available in the HIE by signing an opt-out form.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's Name Print Name of Patient or Legal Guardian)

CHIDREN'S HEART SPECIALISTS OF GEORGIA
FINANCIAL POLICY

If you have medical insurance, we are pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- Co-payments for office services are required at the time of service
- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been made prior to services being rendered.
- Returned checks are subject to a handling fee of $25.00.
- **Patient balances over 90 days must be turned over to a collection agency. You will be billed and are responsible for, all fees involved in that process.**
- A no-show fee of $50.00, which is not billable to insurance, will be charged for any appointment not cancelled with 24-hour notice.

YOU MUST REALIZE:

1. Your insurance is a contract between you and your employer and/or insurance company. While we may be a provider of service, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services, however, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Patient's Name Print Name of Patient or Legal Guardian)

Children's Heart Specialists of Georgia
New Patient Medical History Form

Today's Date_____

Name_____ **DOB**_____ **Age**_____

Reasons for seeing the doctor today:_____
_____

Birth History: Birth Weight: _____ □ Full Term □ Premature □ Vaginal delivery □ C-Section
Any complications during pregnancy:_____

Social History: Mother/Age _____ Father/Age _____ Brothers/Ages _____
Sisters/Ages _____
Ethnicity: □ Caucasian □African American □ Hispanic □ Asian □ Others_____

School and grade:_____ □ N/A
Does anyone in the family smoke? □ Yes □ No
Does the patient smoke? □ Yes □ No □ N/A
Does the patient use recreational drugs? □ Yes □ No □ N/A

Previous Surgeries:_____
_____ □ N/A

Any previous cardiac evaluation: □ EKG_____ □ Echocardiogram_____
□ Heart catherization_____ □ No previous cardiac evaluation or test

Hospitalizations: List all previous hospital admissions:

Reason for hospital admission	Name of hospital	Age at hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: List drug allergies_____
□ Patient has no drug allergies

Current Medications: □ *Taking no medications*

Name of Medication	Dosage	Frequency-

FAMILY HISTORY: ☐ **Family history is unknown.**

Acquired Heart Diseases

Any family members with high blood pressure? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with irregular heartbeats? ☐ No ☐ Yes
Relationship to patient_____ Age of onset_____

Any family members with cholesterol problems? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members who have had a heart attack? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members who have had a stroke? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with congestive heart failure or an enlarged heart? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Heart Surgery/Procedures

Any family members who have had coronary artery stents? ☐ No ☐ Yes
Relationship to patient_____ Age of onset_____

Any family members who have had open heart surgery? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members who have had a pacemaker or defibrillator? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members who have had an ablation? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Structural Congenital Heart Diseases

Any family members who were born with a heart defect? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members who have diagnosed with a heart murmur? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members who have had open heart surgery at a young age? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members who have had any kind of heart of heart procedure? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Arrhythmic Congenital Heart Diseases

Any family members with sudden cardiac death? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with sudden infant death syndrome? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any young individuals in the family who died while playing sports? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any young individuals in the family who died in their sleep? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with sudden or accidental death? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with hypertrophic obstructive cardiomyopathy (HOCM)? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with long QT syndrome or short QT syndrome? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with Brugada's syndrome? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with arrhythmogenic right ventricular cardiomyopathy (ARVC)? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any family members with catecholamine polymorphic ventricular tachycardia (CPVT)? ☐ **No** ☐ **Yes**
Relationship to patient_____ Age of onset_____

Any other relevant family history:_____

REVIEW OF SYSTEMS (Please check all that applies) *Patient does not have any of the symptoms listed below*

Recent weight gain	Recent weight loss	Fatigue easily	Night sweats
Fever			
Headaches	Blurred vision	Hearing loss	Swallowing problems
	Ear drainage		
Chest pain	Fast heart beats	Exercise difficulties	Skipped heart beats
	Faint		
Pass out	Arm pain / numbness	Excessive sweating	Shortness of breath
	Wheezing		
Difficulty breathing	Hoarseness	Congestion	Coughing up blood
	Cough sputum		
Abdominal pain	Nausea/Vomiting	Diarrhea	Heart burn
Constipation	Bloody stools		
Easy bleeding	Easy bruising	Blood in stool	Blood in urine
Heavy cycles (Girls)			
Difficulty urinating	Blood in Urine	Cloudy Urine	Frequent urination
	Urine odor		
Seizures	Weakness	Muscle cramps	Numbness
Falls			
Dizziness	Lightheadedness	Nervousness	Feeling down
Depression			
Swollen lymph glands	Swollen feet	Hands turning blue	Difficulty concentrating
Excessive sweating frequently	Feeling cold frequently	Feeling thirsty frequently	Feeling hot
Muscle stiffness	Swollen Joints	Muscle twitching	Muscle pain
Sores	Rash	Hair changes	Nail changes

Any other symptoms_____
_____

VITAL SIGNS

Weight: _____lbs Height: _____inches

Heart rate:_____beats per minute Resp Rate:_____per minute Pulse ox:_____%

Blood Pressure: RA___/___ LA____/___ RL____/____ LL____/____

Orthostatic Vitals: Supine: BP_____ HR_____ **Sitting:** BP_____ HR___ **Standing:** BP_____ HR____