Karen A. Moore, M.D., F.A.A.P.
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Alison G. Ball, M.D. F.A.A.P.
Wendy N. Davison, CPNP, Nurse Practitioner
Cherri D. Esezobor, CPNP, Nurse Practitioner
Tory M. Banks, CFNP, Nurse Practitioner

Cumberland Pediatrics, P.C
1405 Franklin Gtwy SE, Marietta, GA 30067-8721
Phone: (770) 951-5400 Nurse Line: (770) 955-8291

Registration
(Please Print)

Date_____ Home_____

Patient_____
Last Name First Name Middle Initial

Street Address_____

City_____ State_____ Zip Code_____

Sex ? M ? F Patient's Age_____ Patients Birthdate_____

Parent's Information: **Father** **Mother**

Last Name First Name MI Last Name First Name MI

Employer_____

Business Address_____

Business Phone_____

Social Security #_____

Insurance Information:

Do you have Medical Insurance? _____No _____Yes _____No_____Yes

Name of Insurance Company:

Contact#_____Group#_____ Contact#_____Group#_____

Member ID#_____

In case of emergency, who should be notified? _____
Name Phone#

How did you learn of our practice?_____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physician to release any information acquired in the course of my child's treatment necessary to process insurance claims.

SIGNATURE OF PARENT:_____ DATE_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the Physician of the Medical Benefits and/or Surgical Benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.

SIGNATURE OF PARENT:_____ DATE_____

PEDIATRIC HEALTH HISTORY

A critical part of your child's medical record is his/her medical history. Your child's overall health as well as any medications your child takes could have an important interrelationship with the healthcare your child receives
Please take the time to answer each of the following questions completely in ink. All answers will be treated confidentially. If there is any question you have difficulty answering, please circle it and the doctor will be happy to discuss it with you.

Personal Information

Patient_____ Birthdate____/____/_____ Patient#_____

Mother's Name_____ Telephone: Home_____Work_____

Father's Name_____ Telephone: Home_____Work_____

☐ Female ☐ Male Birthplace ☐ Home ☐ _____ Hospital ☐ _____

Child lives with_____ Nickname_____
(Mother, Father, Parents, etc.)

Prior Physician_____ Tel/Address_____

Child's School_____ Grade_____ Tel/Address_____

Child's Birth History

Maternal Information During This Pregnancy

Caffeine Use: Type_____ Amt/Day_____
Alcohol Use: Type_____ Amt/Day_____
Tobacco Use: Type_____ Amt/Day_____
Street Drugs: Type_____ Amt/Day_____
Type_____ Amt/Day_____
Type_____ Amt/Day_____

Medications: Non-prescription/Prescription

Type/Strength_____ Amt/Day_____

Type/Strength_____ Amt/Day_____

Type/Strength_____ Amt/Day_____

Type/Strength_____ Amt/Day_____

During the pregnancy did you have:

Prenatal care	No	Yes
High Blood Pressure	No	Yes
Gestational Diabetes	No	Yes
Venereal Disease	No	Yes
German (3 Day) Measles	No	Yes
Exposure to Known Causes of Birth Defects	No	Yes
Any illness, Infection, or High Fever	No	Yes

If yes, describe_____
Was Baby Born: Early(<38 Wks) Term(=38 Wks) Late(42 Wks)

Was Baby: Normal Vaginal Breech (bottom first) C-Section

Please describe any complications:_____

_____

_____

Infant Health History (Birth to Present)

Birth Weight_____lbs_____oz Age when discharged from hospital_____
Was your baby:
Jaundiced No Yes age_____ how long_____

Breast fed No Yes _____ months

Formula fed No Yes _____ months Formula_____

Did your baby…

See a doctor for well baby care	No	Yes
See a doctor for illness/problem	No	Yes
Shots up to date	No	Yes

Describe_____
_____
_____
_____
_____

Health History

Does your child have or has your Child ever had:
(Please Circle)

Mumps, Measles	No	Yes	Developmental Problems	No	Yes
Chicken Pox	No	Yes	Croup	No	Yes
Eczema/Skin Problems	No	Yes	TB/Lung Diseases	No	Yes
Pneumonia	No	Yes	High Blood Pressure	No	Yes
Asthma/Wheezing	No	Yes	Kidney/Bladder Problems	No	Yes
Cancer	No	Yes	Sexually Trans. Disease	No	Yes
Hepatitis	No	Yes	High Cholesterol	No	Yes
HIV/AIDS	No	Yes	Handicaps/Disabilities	No	Yes
Hemophilia	No	Yes	Diabetes	No	Yes
Abnormal Bleeding	No	Yes	Rheumatic Fever	No	Yes
Allergies	No	Yes	Congenital Heart Defect	No	Yes
Frequent Ear Infections	No	Yes	Heart Murmur	No	Yes
Frequent Colds	No	Yes	Convulsions/Epilepsy	No	Yes
Sore Throats	No	Yes	Emotional Disorders	No	Yes
Dental Problems	No	Yes	Suicide Attempts	No	Yes
Bed Wetting	No	Yes	Thumb Sucking	No	Yes
Eye Problems	No	Yes	Toilet Training Problems	No	Yes
Speech Problems	No	Yes	Diarrhea or Constipation	No	Yes
Hearing Problems	No	Yes	Irritable/Temper Problems	No	Yes
Emotional Problems	No	Yes	Nightmares/Sleep Problems	No	Yes
Disciplinary Problems	No	Yes	Feeding/Eating Problems	No	Yes
Meningitis	No	Yes			

Family Health History

Relationship	Age	Age at & Cause of Death
Mother	_____	_____
Father	_____	_____
Siblings	Age(s) of living	Age(s) at death
Male	_____	_____
Female	_____	_____

Family Medical Problems

Please identify any medical problems blood relatives have or ever have had.

Condition	No	Yes	Family Member(s)
Birth Defects	___	____	_____
Genetic Defects	___	____	_____
Mental Retardation	___	____	_____
Allergies	___	____	_____
Lung Disease	___	____	_____
Asthma	___	____	_____
Bone/Joint Disorder	___	____	_____
Rheumatoid Arthritis	___	____	_____
Muscle Disorders	___	____	_____
Skin Disease	___	____	_____
Eye or Ear Disorders	___	____	_____
Cancer	___	____	_____
Diabetes	___	____	_____
Thyroid Disease	___	____	_____
Heart Disease	___	____	_____
Anemia/Blood Disorder	___	____	_____
High Blood Pressure	___	____	_____
Kidney Disease	___	____	_____
Rheumatic Fever	___	____	_____
Tuberculosis (TB)	___	____	_____
Seizures/Convulsions	___	____	_____
Mental Disease/Disorder	___	____	_____
Venereal Disease	___	____	_____
HIV/AIDS	___	____	_____
Other	___	____	_____

Hospitalizations or Serious Illnesses

Please list any hospitalizations, serious and/or unusual illnesses which your child has experienced.

Date	Hospitalizations/Illness	Hospital/Physician's Name	City. State

Medications

Please list all medications your child currently takes.

Date	Medication/Strength	Frequency	Condition

Allergies

Please list allergies, sensitivities, and/or reactions to any drugs.

_____
_____
_____

To the best of my knowledge, the question, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary services my child may need.

_____ _____
Signature of parent or guardian Date

Doctor's Review_____
_____
_____
_____

_____ _____
Doctor's Signature Date

Health History Update **Physicians Use Only**

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____

Cumberland Pediatrics

1405 Franklin Road
Marietta, GA 30067
www.cumberlandpediatrics.com
770-951-5400 FAX 770-951-5408

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

N/A

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

11/01/2013

This Notice of Privacy Practices applies to the following organizations.

We are not an entity of OCHA

Michael Hamilton, HIPPA Point, Cumberland Pediatrics, 770-951-5400, cpedz@yahoo.com or Cathy Hudson, Cumberland Pediatrics, 770-951-5400, cathy@cumberlandpediatrics.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Cumberland Pediatrics

I have received and read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Cumberland Pediatrics with my authorization and consent to use and disclose my protected healthcare information (PHI) for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature/Legal Guardian Date

_____ _____
Authorized Facility Signature Date