Vidalia Pediatric Clinic
303 Harris Industrial Blvd, Ste 3
Vidalia, GA 30474
Phone: (912) 537-9355

All information **MUST** be filled out in order for services to be provided. Thank you.

Patient Information

Date: _____

_____

First Name *Middle Name* *Last Name*

Physical Address: _____
Street City State Zip

Mailing Address: _____
(If Different from Above) Street City State Zip

Date of Birth: _____ *Social Security Num*:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Sex: □ Male □ Female *Race*: □African American □Asian □Caucasian □Hispanic □Indian □ Native American

Insurance Type: □Medicaid □Wellcare □Amerigroup □Peachstate □Other: _____

Can we text cell phone for appointment reminders: □ Yes □ No

Parent Email Address:_____

List of Child's Siblings (if any): _____

Mothers Name: _____

Address: _____
Street City State Zip

Social Security: _____ *Home Number*: _____

Date of Birth: _____ *Cell Number*: _____

Fathers Name: _____

Address: _____
Street City State Zip

Social Security: _____ *Home Number*: _____

Date of Birth: _____ *Cell Number*: _____

Emergency Contact: _____
Name Number Relationship

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Release Form for Individuals in Care of Patient

Parent/Guardian Name: _____

Patient's Name: _____ Patient's Date of Birth: _____

I give Vidalia Pediatric Clinic permission to speak with the following people regarding my child's health status; including diagnosis, treatment options and plans, and payments for health services I receive from Vidalia Pediatric Clinic. I give Vidalia Pediatric Clinic permission to treat my child in my absence when brought by the following people.

This consent is valid until such time as I provide Vidalia Pediatric Clinic written revocation of it.

Vidalia Pediatric Clinic may speak with:

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Parent Signature: _____
Date: _____

VIDALIA PEDIATRIC CLINIC
Your child, your trust, our care.

Authorization to Release Medical Records

Patient Name _____Previous Names_____
Address_____
Birthdate _____Phone Number _____

Previous Provider:	Name: _____ Address: _____ _____ Phone: _____ Fax: _____
Requestor	Name: **Vidalia Pediatric Clinic** Address: **303 Harris Industrial Blvd, Suite 3** **Vidalia, GA 30474** Phone: **(912) 537-9355** Fax: **(912) 335-4804** Delivery Preference: _X_ US Mail ___ FEDEX _X_ Fax
Information To Be Released	□Any and all records □Clinic Notes □Immunizations □Pathology Reports □X-ray/Radiology Reports □Films □EKG/ECHO Reports □Discharge Summary □History and Physical Exam □Consultation Reports □Lab Results □Operative Reports □Emergency Services □Other (please specify):_____
Reason for Release	□Continued care by another provider □Personal Use □Insurance Claim □Attorney Review □Other (please specify): _____

□ With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here:_____
□ I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
□ This authorization will automatically expire one year from the date of my signature, or _____ (period of time, for example 2 days, or 3 weeks, or 5 months) from my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Georgia.
□ I understand there may be a retrieval and copy charge associated with the release.
□ I understand that once information is released pursuant to this authorization, Vidalia Pediatric Clinic cannot prevent the re-disclosure of the information to another third party.
□ I understand this authorization must be filled out completely, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.
□ Except for research-related treatment, Vidalia Pediatric Clinic will not condition treatment on my signing this authorization.

_____ _____
Signature of patient / Authorized Person Date

_____ _____
Authorized person's authority to sign (Parent, guardian, power of attorney, etc.) Date

_____ _____
Witness Date

If you have any questions, please call the receptionist at (912) 537-9355.

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We now have the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

Patient Portal, Email and Text Message Consent for Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Vidalia Pediatric Clinic.

Patient Name (Print):_____ DOB: _____

Parent/Guardian Name: _____

Cell Phone Number (_____)_____-_____

Carrier: ☐ AT&T ☐ Boost ☐ Cellular One ☐ Nextel ☐ Page Plus ☐ Sprint ☐ T-Mobile ☐ U.S. Cellular ☐ Virgin Mobile USA ☐ Verizon ☐ Other: _____

Email Address:

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I understand it is my responsibility to update the phone number(s) and the email address Vidalia Pediatric Clinic has on file.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Birth Hx: Birth weight: _____ Gestation age: _____ C-section / vaginal delivery

Surgical history: _____

Social history:
Lives with: _____

Smoke exposure: (circle) No exposure / occasional exposure / frequent exposure

Smoke detectors in home: Yes / No

Number of siblings: ___ Brothers _____ Sisters

Family History:

Medical Condition	Family Member (check if yes)
Asthma	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Autoimmune (specify) Lupus Rheumatoid Arthritis (JRA) Sjogren's Syndrome	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Cancer (specify)	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Diabetes Type 1 (juvenile onset) Type 2	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
High Blood Pressure	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Heart attack/stroke	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____

Crohn's Disease Celiac Disease Diverticulitis Ulcerative colitis Multiple sclerosis Dementia / Alzheimer	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
High cholesterol / or Lipids	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Migraines	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Seizures (specify) Epilepsy Febrile seizures Convulsions	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Sickle cell or other anemia	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Thyroid problems	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Psychiatric disorders (specify) Anxiety Depression Mental illness (Bipolar, Schizophrenia, etc.)	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Other: Genetic disorder Eating disorder Autism Neurofibromatosis Other: _____	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____