

Pediatric Associates, P.C.
3000 Johnson Ferry Road
Suite 204
Marietta, Georgia 30062
770-993-2922

Date _____

Patient and Family History

Your kindness in furnishing the following information will be appreciated. The information will be used in strict confidence to prepare your child's chart.

Child's Full Name _____ Male _____ Female _____
 Birth Date _____ Name Child Is Called By _____
 Address _____ Apt # _____
 City _____ State _____ Zip _____
 Who is responsible for this child's medical bills? _____

Father's Full Name _____
 Address _____
 SS # _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Firm or Business Name _____
 Address _____
 Insurance Co: _____
 ID or Contract # _____
 Group # _____

Mother's Full Name _____
 Address _____
 SS # _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Firm or Business Name _____
 Address _____
 Insurance Co: _____
 ID or Contract # _____
 Group # _____

In case of an emergency, whom should we call (other than parents)? _____
 Who referred you to our office? _____
 If you have other children please list names and birth dates. _____

Family History

	Birth Date	Ht.	Wt.	Medical Problems	Education
Mother					
Father					

Anyone in the family with:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Convulsions or Seizures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |