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Pediatric
Physicians,
PC

Health
Information
and PIN

PPPC Account # _____

Child's full name: _____ Male Female Birth date: ___/___/___
Today's date: ___/___/___ Person completing: _____ Relationship: _____

Past Medical History

Birth Complications: _____

Hospitalizations/Dates: _____

Operations/Dates: _____

Drug/Food Allergies: _____

Specialists seen: _____

Child has had prior problems with: (please write in details)

Eyes/ears/nose/throat:

Asthma/wheezing:

Allergies:

Heart:

Gastrointestinal tract:

Genital tract:

Neurologic:

Skin:

Bleeding:

Learning/Behavior/ADD:

Fainting:

Has child had chicken pox? Circle one: YES (provide approx date: _____) / NO / Vaccinated

Social History

Parents: married divorced separated (If divorced and both parents do not have the right to access medical record, provide court order.)

Lives with: _____

Siblings: _____

Family Medical/ Psychiatric History (Please list details along with family member(s) affected. Include siblings, parents, aunts, uncles, and grandparents)

Asthma/Wheezing:

Bleeding:

Cancer (list types):

Diabetes:

High blood pressure:

High Cholesterol:

Heart problems:

Psychiatric disorder:

Thyroid disease:

Unexplained sudden death:

Other:

PIN : _____

Please choose a PIN, usually four digits or letters long. We will only discuss protected health information with individuals who have your PIN. Patients 18 years and up must select their own.

Signature, person completing form:

Other information