ALLERGY & ASTHMA CLINIC OF SOUTHEAST GEORGIA
ACUTE CARE CLINIC
CHILD INFORMATION SHEET

PATIENT NAME:_______________________________ **DATE:**____________________________
CALLED NAME: __________________
SEX: ________**M F**________ **DOB:**____________ **SSN**____________________**(required)**

Mother's Name:	DOB:	**Father's Name**	DOB:
SSN:	Home phone:	SSN:	Home phone:
ADDRESS	City/State/Zip	Address:	City/State/Zip
Employer:	Employer address:	Employer:	Employer address:
Work phone:	Cell phone:	Work phone:	Cell phone:

Parent responsible for payment:_________________________________
*****Emergency Contact (other than parent): Name:**______________________ **Phone:**____________

CHILD'S MEDICAL HISTORY

Please list past and present medical problems:____
____

Reason for visit today: ____
(If any, name of referring physician:________________________)

List child's current medications: ____

List any hospitalizations, operations, etc:____

Please list any know allergies to medications, dyes, foods, etc:______________________________
PHARMACY NAME/PHONE NUMBER:____
How did you hear about our office?:____

	Age			Please list any known allergies.
Mother				
Father				
Brothers				
Sisters				

Immunizations

1. Tetanus Y_____ N______
2. Polio Y_____ N______
3. Typhoid Y_____ N______
4. MMR Y_____ N______
5. HEP B Y_____ N______
6. DPT Y_____ N______

INSURANCE INFORMATION

Name of Insurance:_________________________ Policy Holder Name:_______________________
Policy No.:____________________________ Group No.______________________

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have the above insurance coverage and assign directly to Dr. Conner all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature:____________________________________ Date:_____________________________