Northside Pediatrics FAQ

When is the office open?

- Monday through Friday, 8:30 am – 5:00 pm (First appointment 8:45 am, last appointment 4:00 pm)
    - Monday morning only, Walk-in Acute Monday (WAM) Clinic, 7:30 am – 8:30 am
- Saturday, 8:30 am until closing, depending on patient needs

How do I schedule an appointment?

- Well child checks can be scheduled up to 3 months in advance.
    - Call our main office line 770-928-0016 (Woodstock) or 404-256-2688 (Sandy Springs).
- Sick visits are scheduled on the same day. The sick visit phone line opens at 7:30 am weekdays and 8:00 am Saturday. It is available all day long, including the lunch hour, to quickly schedule sick visits.
    - Call our dedicated sick line 770-592-6719 (Woodstock) or 404-256-0447 (Sandy Springs).
- Please let our scheduling staff know if you have a provider you would like to see or if you prefer the first available appointment.

What should I do before my child's first appointment?

Please complete the attached medical history and family history forms. Also ask your last pediatrician to send us your child's medical record, so it can be reviewed ahead of time.

What is WAM clinic?

Every Monday, Northside Peds offers Walk-in Acute Monday (WAM) clinic from 7:30 – 8:30 am for quick sick visits such as sore throat, earaches, and fever. WAM clinic works on a first-come, first-served basis with 10 available slots during that hour. No appointment needed!

I'm not sure if my child needs to be seen. How do I figure that out?

During business hours, the Northside Peds phone nurse can help you assess symptoms, determine if your child needs a visit, and schedule an appointment if needed. Our phone nurse can also answer common questions and offer first-line home treatment options if available.

What if my child is sick outside of business hours?

Kids always seem to get sick when the office is closed. For emergency after-hour questions, we use Children Health Care of Atlanta's nurse advice line. If the nurse cannot answer your question, the on-call Northside Peds doctor or nurse practitioner will be paged and call you back.

Do you have laboratory on site?

Yes! If your child's provider orders blood work, this can be drawn on-site by our laboratory technicians. Many tests are even processed in-house, allowing for same day results and clinical decisions. Our laboratory is not open during weekends or WAM and does not draw samples ordered by non-Northside Peds providers.

Do you accept my insurance?

We accept many insurance plans – please call our office to discuss your specific plan.

We know picking a pediatrician is an important decision, and we are honored you chose us!
We look forward to meeting you in the office.

Northside Pediatrics New Late Arrival Policy

In our efforts to minimize your wait time, our office has implemented a new late arrival policy. We want to ensure that families who arrive on time do not wait longer than necessary and to continue to provide the top-notch care your family deserves.

If your child is more than 15 minutes late for an appointment, the appointment may need to be rescheduled. Unfortunately, when even one patient arrives late, it can throw off the entire schedule for that day. In addition, rushing or "squeezing in" an appointment shortchanges our patients and contributes to decreased quality of care.

We will try to accommodate late-comers as best as possible but refuse to compromise on the quality and timely care provided to our other patients. You may be given the option to wait for another later appointment time on the same day if one is available, but we cannot guarantee that there will be an opening for your child to be seen on the same day.

New patients need to arrive at the office at least 15 minutes prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time.

The doctors and staff at Northside Pediatrics truly appreciate your cooperation with this policy so that we can continue to provide both excellent and timely medical care to your children.

Patient Medical History Form

Date _____

Patient Name _____ Birth Date _____

Your Name _____ Relationship to Patient _____

Medication Allergies _____ Chronic Medications _____

We are updating our system. If you are a new or established patient, please complete the following information for your child. Please complete a separate form for each patient. Additional forms may be printed from our website www.northsidepediatrics.com.

Pregnancy History

Did mom see a perinatologist during pregnancy?	❒Yes	❒No	Did mom smoke during pregnancy?	❒Yes	❒No
Did mom have an abnormal ultrasound during pregnancy?	❒Yes	❒No	Did mom drink any alcoholic beverages during pregnancy?	❒Yes	❒No
Has mom had breast surgery?	❒Yes	❒No	Has mom had any miscarriages, still births, or abortions?	❒Yes	❒No

Were there any complications during pregnancy? If so, please list: _____
_____

Birth History

❒Full term pregnancy ❒Premature birth at ___ weeks ❒Twin or multiple births at ___ weeks
Baby's weight at birth? _____

Were there any problems during labor? If so, please list: _____
_____

Type of Delivery: ❒Vaginal ❒C-Section Apgars _____ Was the baby breech (feet first)? ❒Yes ❒No

Did the baby have any problems during the newborn period? If so, please list: _____
_____

Was the child the product of IVF? ❒Yes ❒No Was the child the product of artificial insemination? ❒Yes ❒No

Was the child the product of a donor egg? ❒Yes ❒No Was the child adopted? ❒Yes ❒No

Developmental

Sat alone at _____mos. Walked at _____ mos. Words at _____ mos. Sentences at _____ mos.

Were there any concerns for your child's development in the past? ❒Yes ❒No

Does the child have any disability? ❒Yes ❒No If yes, please specify: _____

Has your child ever needed to see a physical, speech or occupational therapist? If so, please list: _____
_____

10/2018

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Provider Initials: _____
Entered By: _____

Family History Form

Date: _____

Patient Name:_____ **DOB:**_____

Has anyone in your family been diagnosed with the following health issues? Please be sure to only consider the **CHILD'S parents, siblings, grandparents, aunts, uncles, first cousins, etc. Please also indicate/write next to each diagnosis which first degree family member has or had each health issue (i.e. maternal aunt, paternal grandfather, etc.).**

Allergies
Asthma ❒Yes ❒No
Environmental ❒Yes ❒No
Food ❒Yes ❒No

Birth Defects ❒Yes ❒No

Bleeding Disorders ❒Yes ❒No

Cancer ❒Yes ❒No

Cardiovascular
Heart Attack before 50 ❒Yes ❒No
Stroke before 50 ❒Yes ❒No
High Blood Pressure ❒Yes ❒No
High Cholesterol ❒Yes ❒No
High Triglycerides ❒Yes ❒No
Other ❒Yes ❒No

Development
Learning Disorder ❒Yes ❒No
Developmental Disorder ❒Yes ❒No
Autism ❒Yes ❒No
ADD/ADHD ❒Yes ❒No
Other ❒Yes ❒No

Diabetes
Type I (Juvenile) ❒Yes ❒No
Type II (Adult) ❒Yes ❒No

Gastrointestinal
Celiac Disease ❒Yes ❒No
Inflammatory Bowel Disease ❒Yes ❒No
Irritable Bowel Syndrome ❒Yes ❒No
Peptic Ulcer Disease ❒Yes ❒No
Other ❒Yes ❒No

Genetic Disorders ❒Yes ❒No

Hearing Loss/Deafness ❒Yes ❒No

Kidney Disease
Kidney Reflux ❒Yes ❒No
Recurrent Infections ❒Yes ❒No
Congenital Malformations ❒Yes ❒No
(abnormally formed kidneys)
Kidney Failure/Transplant ❒Yes ❒No
Other ❒Yes ❒No

Lazy Eye ❒Yes ❒No

Mental or Emotional Disorders
Anxiety ❒Yes ❒No
Bipolar Disorder ❒Yes ❒No
Depression ❒Yes ❒No
Schizophrenia ❒Yes ❒No
Substance Abuse ❒Yes ❒No
(drugs or alcohol)
OCD ❒Yes ❒No
Other ❒Yes ❒No

Migraines ❒Yes ❒No

Obesity ❒Yes ❒No

Seizure Disorder ❒Yes ❒No

Tyroid Disease
Hypothyroid ❒Yes ❒No
Hyperthyroid ❒Yes ❒No
Tyroid Tumor ❒Yes ❒No

Please list any other problems in the family:

_____

_____

_____

Office Use Only
Provider:_____
Entered by:_____

Past Medical History Form

Date: _____

Patient Name:_____ **DOB:**_____

Has your child ever been diagnosed with any of the following health issues? Please indicate each one.

Allergies
Environmental ❒Yes ❒No
Food ❒Yes ❒No
Allergy Testing ❒Yes ❒No
Allergy Shots ❒Yes ❒No
Eczema ❒Yes ❒No
History of Anaphylaxis? ❒Yes ❒No
Other (Please List)_____

Cardiac
Heart Defect ❒Yes ❒No
Other (Please List)_____

Developmental/Genetic Disorders
Down Syndrome ❒Yes ❒No
Turner Syndrome ❒Yes ❒No
Mitochondrial Disease ❒Yes ❒No
Autistic Spectrum Disorder ❒Yes ❒No
Other (Please List)_____

Ear/Nose and Throat
Ear Infections (more than 5 in a year) ❒Yes ❒No
Tonsillitis (recurrent) ❒Yes ❒No
Sleep Apnea ❒Yes ❒No
Other (Please List)_____

Endocrine
Hypothyroid ❒Yes ❒No
Hyperthyroid ❒Yes ❒No
Type I Diabetes ❒Yes ❒No
Type II Diabetes ❒Yes ❒No
Other (Please List)_____

Eye
Strabismus (crossed eyes) ❒Yes ❒No
Amblyopia (decreased vision) ❒Yes ❒No
Other (Please List)_____

Gastrointestinal
Reflux ❒Yes ❒No
Constipation ❒Yes ❒No
Chronic Abdominal Pain ❒Yes ❒No
Celiac Disease ❒Yes ❒No
Other (Please List)_____

Genitourinary
Urinary Infections ❒Yes ❒No
Menstrual Problems ❒Yes ❒No
Vesicoureteral Reflux (kidney reflux) ❒Yes ❒No
Bedwetting (over the age of 6) ❒Yes ❒No
Other (Please List)_____

Hematology
Anemia ❒Yes ❒No
Other (Please List)_____

Infections/Immunology
Chicken Pox ❒Yes ❒No
MRSA ❒Yes ❒No
Immunodeficiency ❒Yes ❒No
Other (Please List)_____

Lung
Pneumonia ❒Yes ❒No
Asthma or wheezing ❒Yes ❒No
RSV (respiratory syncytial virus) ❒Yes ❒No
Other (Please List)_____

Mental Health
Depression ❒Yes ❒No
Anxiety ❒Yes ❒No
Other (Please List)_____

Neurologic
Recurrent Headaches ❒Yes ❒No
Cerebral Palsy ❒Yes ❒No
Seizure Disorder ❒Yes ❒No
ADHD
Predominantly Inattentive ❒Yes ❒No
Predominantly Hyperactive ❒Yes ❒No
Combined ❒Yes ❒No
Other (Please List)_____

Obesity ❒Yes ❒No

Oncology/Cancer ❒Yes ❒No
Other (Please List)_____

Orthopedic
Fractures and When ❒Yes ❒No
What bone?_____
What bone?_____
What bone?_____
Scoliosis ❒Yes ❒No
Other (Please List)_____

Please list any details if you answered **"Yes"** to any of the above:

List any hospitalizations that your child has had:

Other illnesses:

Past surgery:

Sees Specialist Doctor: ❒Yes ❒No If yes, what kind?

For what?

Name of Specialist Doctor(s):

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Provider:_____
Entered by:_____

11/5/18

Social History Form

Date _____

Patient Name _____ Birth Date _____

Please complete the following information for your child.

Recent Changes: ❒Move ❒Loss of Job ❒Other, please list: _____
❒Travel ❒Death Date of change: _____

Parents Marital Status: ❒Married ❒Divorced Date: _____ ❒Separated Date: _____
❒Single ❒Widowed Date: _____ ❒Unmarried Living Together
❒Remarried (Circle one: Mom or Dad) Date: _____

Parents Occupation: Mom _____ Dad _____

Members of Household: ❒Mom ❒Brother #_____ ❒Other, please list: _____
❒Dad ❒Sister #_____

Other Living Arrangements: ❒Legal Guardian ❒Adopted ❒Foster Care
❒Parent(s) Incarcerated ❒Parent(s) in Drug/Alcohol Rehab
❒Child Protective Services Involved Who is primary care giver? _____

Is there tobacco or smoke exposure? ❒Yes ❒No

Are there guns in the home? ❒Yes ❒No ❒Decline to answer If yes, are they? ❒Secured ❒Unsecured

School Arrangements: ❒Daycare ❒Preschool ❒In School ❒Home School
What grade? _____ Name of school_____

Any clubs or athletic teams? ❒Yes ❒No If yes, please list: _____

_____

Any pets in the home? ❒Dog ❒Cat ❒Other, please list: _____

TB exposure risks: ❒Contact w/TB ❒Contact w/HIV ❒Contact w/Immigrant ❒Contact w/Prisoner
❒Contact w/Homeless ❒Immunosuppression ❒Foreign Travel (for 1 month+)
❒High Risk Community ❒Other, please list: _____ ❒None

Lead exposure risks (if your child is under 6 years of age): ❒Older Home (before 1978) ❒Recent Remodeling
❒Paint Removal ❒Occupational Exposure ❒Pica (child eats dirt, rocks, paper, plastic, etc.)
❒Other, please list: _____ ❒None

Office Use Only
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Entered By: _____

Northside Pediatrics
The best care for your kids

Release of Medical Records

I request that: _____
(Physician)

_____
(Practice)

_____
(Address)

_____

_____ _____
(Telephone) (Fax)

Dr. Sally J. Marcus
Dr. Allison B. Hill
Dr. Amy J. Hardin
Dr. Jeffrey C. Hopkins
Dr. Natalie M. Metzig
Dr. Tiji M. Philip
Dr. Adele H. Goodloe
Dr. Reshmi Basu
Sara D. Dorsey, MSN, CPNP
Kathryn R. Hart, MSN, CPNP
Dr. Michael K. Levine, Emeritus
Dr. Ruth C. Brown, Emeritus
Dr. Jonathan D. Winner, Emeritus

Release the medical records and immunization dates of:

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Please send the records to: Northside Pediatrics
6095 Barfield Road
Suite 200
Sandy Springs, GA 30328

I understand this consent is voluntary and that I may revoke it in writing at any time. This consent will remain in effect for no more than 90 days from the date I sign the consent. I also understand that my medical records may include information including that on mental psychiatric or psychological assessment or treatment, sexually transmitted diseases (including HIV), genetic testing, drug or alcohol treatment, or pregnancy.

I understand that the information received by Northside Pediatrics may be subject to re-disclosure by them and may no longer be protected by the federal HIPAA Privacy Rule.

Sandy Springs
6095 Barfield Road
Suite 200
Sandy Springs, GA 30328
Tel: 404-256-2688
Fax: 770-685-7114

Woodstock
250 Parkbrooke Place
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www.northsidepediatrics.com