

# 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](http://www.northsidepediatrics.com).

## Pregnancy History

Did mom see a perinatologist during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did mom smoke during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did mom have an abnormal ultrasound during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did mom drink any alcoholic beverages during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has mom had breast surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has mom had any miscarriages, still births, or abortions? <input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_

### Office Use Only

Provider Initials: \_\_\_\_\_

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.

<b>Allergies</b>		<b>Gastrointestinal</b>		<b>Neurologic</b>	
Environmental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Celiac Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>ADHD</b>	
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please List) _____		Predominantly Inattentive	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of Anaphylaxis?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Predominantly Hyperactive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please List) _____		<b>Genitourinary</b>		Combined	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Urinary Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please List) _____	
<b>Cardiac</b>		Menstrual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vesicoureteral Reflux (kidney reflux)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Obesity</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please List) _____		Bedwetting (over the age of 6)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Other (Please List) _____		<b>Oncology/Cancer</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Developmental/Genetic Disorders</b>				Other (Please List) _____	
Down Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Hematology</b>			
Turner Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Orthopedic</b>	
Mitochondrial Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please List) _____		Fractures and When	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autistic Spectrum Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No			What bone? _____	
Other (Please List) _____		<b>Infections/Immunology</b>		What bone? _____	
		Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	What bone? _____	
<b>Ear/Nose and Throat</b>		MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Infections (more than 5 in a year)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunodeficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please List) _____	
Tonsillitis (recurrent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please List) _____			
Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other (Please List) _____		<b>Lung</b>			
		Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Endocrine</b>		Asthma or wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hypothyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	RSV (respiratory syncytial virus)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hyperthyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please List) _____			
Type I Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Type II Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Mental Health</b>			
Other (Please List) _____		Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Eye</b>		Other (Please List) _____			
Strabismus (crossed eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Amblyopia (decreased vision)	<input type="checkbox"/> Yes <input type="checkbox"/> 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): \_\_\_\_\_

**Office Use Only**  
Provider: \_\_\_\_\_  
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 (abnormally formed kidneys) Yes No  
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 (drugs or alcohol) Yes No  
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:

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Office Use Only

Provider: \_\_\_\_\_

Entered by: \_\_\_\_\_

## 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

10/2018

### Office Use Only

Provider Initials: \_\_\_\_\_

Entered By: \_\_\_\_\_



## 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. Metzsig
- 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  
250 Parkbrooke Place  
Suite 200  
Woodstock, GA 30189

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  
Suite 200  
Woodstock, GA 30189  
Tel: 770-928-0016  
Fax: 678-324-5018

\_\_\_\_\_  
Signature of Parent or Legal Guardian Date

\_\_\_\_\_  
Relationship to patient