

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? <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: _____

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		Gastrointestinal		Neurologic	
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	ADHD	
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) _____		Genitourinary		Combined	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Urinary Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please List) _____	
Cardiac		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	Obesity	<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) _____		Oncology/Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental/Genetic Disorders				Other (Please List) _____	
Down Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hematology			
Turner Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic	
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) _____		Infections/Immunology		What bone? _____	
		Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	What bone? _____	
Ear/Nose and Throat		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) _____		Lung			
		Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Endocrine		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	Mental Health			
Other (Please List) _____		Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Eye		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: _____

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. 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
250 Parkbrooke Place
Suite 200
Woodstock, GA 30189

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

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.