34474-08

Children's Healthcare of Atlanta
at Hughes Spalding

RONALD McDONALD CARE MOBILE® REGISTRATION AND HEALTH HISTORY

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Patient Information: Please complete all of this section

_____ _____

Student's Last Name First Middle

_____ _____

Student's Address City State Zip

_____ Sex: M F

Date of Birth Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other Declined Unknown

Race: American Indian/Alaska Native Asian Black/African American White
Native Hawaiian/other Pacific Islander Other Declined Unknown

School: _____ Grade: _____ Teacher: _____

Primary Care Physician: _____ Date of Last Well-Check: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Parent/Guardian Information:

Parent/Guardian's Name: _____ Parent Date of Birth: _____

Parent Employment status (Please Circle One): Full Time Part Time Self Employed Not Employed Other

Address (if different from student): _____

Preferred Language: _____ Email Address: _____

Home Phone #: _____ Mobile Phone #: _____

May we leave a message? Yes No Preferred form of contact? Call Text Email

Insurance Information: <u>Please fill in all the information so that we do not need to copy your card.</u>

My child has: ___ No Insurance ___ Peach State ___ Amerigroup ___ Well Care ___ Medicaid

ID# _____ (ID# required for billing) Effective Date: _____

___Private/Commercial Insurance Provider **(please provide <u>ALL</u> details below)**

Primary Insurance Company: _____ Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Effective Date: _____ Relationship to Student: _____

Member ID or Policy# _____ Group # _____ Group Name: _____

(Please call us if you have any billing questions or concerns throughout the year 404-785-9480)

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Emergency Contact Information: Alternate contact if parent/guardian is unable to be reached.

Name: _____ Relationship: _____ Phone #: _____

(May We Leave A Message?) Yes No

Patient's Medical History

ADD/ADHD	Yes	No	Hay Fever	Yes	No
Headaches	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Kidney/Renal Disease	Yes	No
Bladder/Urinary Problems	Yes	No	Nosebleeds	Yes	No
Blood Disorder	Yes	No	Pneumonia	Yes	No
Bowel Problems/Constipation	Yes	No	Premature Birth	Yes	No
Cancer/Leukemia	Yes	No	Spine Disorders	Yes	No
Depression/Anxiety	Yes	No	Seizures	Yes	No
Diabetes Mellitus	Yes	No	Sickle Cell	Yes	No
Earaches/Ear Infections	Yes	No	Stomach Aches	Yes	No
Eczema	Yes	No	Wears Glasses or Contacts	Yes	No
Environmental Allergies	Yes	No	Wears Hearing Aid	Yes	No
Frequent Infections	Yes	No	Weight Issues	Yes	No

Other (please list): _____

Current Medications:

Does your child take any medications? Yes No

If yes, please list medications: _____

_____

Allergies:

Does your child have allergies? Yes (if yes, please list allergies below) No

Foods: _____

Medications: _____ Animals or insects: _____

Does your child carry an Epi Pen? Yes No

Asthma Information:

Does your child have an inhaler? Yes No Type of inhaler:_____

Will your child bring inhaler to school? Yes No Does child use a nebulizer at home? Yes No

Would you like for us to call you to schedule an appointment to check on your child's asthma? Yes No

Surgeries/Hospitalizations:

Has your child stayed overnight in the hospital? Yes No

Has your child had a serious injury? Yes No

Has your child had surgery? Yes No

If yes, please list: _____

Number of visits to the Emergency Room last year?

_____

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Family History

Have any Blood Relatives of your child had the following problems? (Please check all that apply.)

☐ Anemia	☐ AIDS	☐ High Blood Pressure	☐ Sickle Cell
☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ Drugs
☐ Headaches/Migraine	☐ Muscle or Joint Problems	☐ Stroke	☐ Tuberculosis
☐ Sudden Infant Death	☐ Arthritis/Birth Defect	☐ Alcoholism	☐ Seizures
☐ Early Deafness	☐ Cancer	☐ Heart Disease	☐ Cystic Fibrosis

Social History

Exposed to cigarette smoke at home? Yes No

Living with parents? Yes No

Do you have pets? Yes No

Exposed to mold/mildew at home? Yes No

Who helps take care of your child? _____

Type of Pets: _____

Signature	Printed Name	Relationship to Student	Date/Time
_____	_____	_____	_____