INCOMING NEW PATIENT QUESTIONNARIE

**1)Patient(s) name D.O.B. List all medical problems /daily medications**

**1.1 ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1.2 ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1.3 ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1.4 ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2) Current health insurance (please circle all applicable)**

**Aetna, Ambetter, Alabama Medicaid, Amerigroup , BCBS, Caresource, Champva , Cigna, Humana, Medicaid of Georgia, PeachState, Tricare, UMR , United, Others(** please specify) **­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3) Name of Child(ren)’s previous physician &/or practice: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_Telephone no: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4) Reason for transferring \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5) How did you learn about us:** Google **or** website **or** Web MD **or** Vitals **or**

Referred by a friend/relative **or** Phonebook **or** Others **­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6) Are you willing to abide by the policies of Columbus Children’s Clinic, LLC on**

6.1) Visits by appointments only **Yes** **No**

6.2) 24-72 hours lead time for request on shot records, school forms, wic forms, FMLA and other patient care related letters, applications. **Yes No**

6.3) Outside treatment referrals when necessary for patient care **Yes No**

6.4) Administering vaccines for all vaccine preventable disease **Yes No**

6.5) Parent/guardian responsibility for informing address change, insurance change, telephone number change, denied claims **Yes No**

**7) Was DFACS ever involved with any of your children? Yes No**

**Certified True by ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s/Guardian name Parent/Guardian signature**

**Contact Phone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_**