

Pediatric Pulmonology of Central Georgia

1062 Forsyth Street

Lanier Building, Suite 2C

Macon, GA 31201

Phone: (478) 755-0036

Fax: (478) 755-1254

**Please Print and Provide Front Desk with your Photo ID and Insurance Card**

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Race: \_\_\_\_\_ Language: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Telephone Number for Appointment Reminder Calls: \_\_\_\_\_

Emergency Contact Name and Telephone Number: \_\_\_\_\_

Parent/Guardian Email for Appointment Reminders: \_\_\_\_\_

Current Insurance Company Name: \_\_\_\_\_

Pharmacy Name, Street and City: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**List of Childs Medication (We will NOT be able to see you without your child's medications listed at every visit.)**

Name (spell as best you can)	Strength	Dose	How Given (by mouth, nebulizer, Gtube)	How Often
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Infant/Child Formula: \_\_\_\_\_ Given by: \_\_\_\_\_ How much: \_\_\_\_\_ When: \_\_\_\_\_

List Any Known Allergies: \_\_\_\_\_

Smokers Living in Home: \_\_\_\_\_ Pets: \_\_\_\_\_ Date of Last Chest X-ray: \_\_\_\_\_

**List Updates/Changes below:**

Medical History of Patient?

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Family History? (New illness in family) \_\_\_\_\_

Social History? (People living in home) \_\_\_\_\_

Name of Person Completing this Form: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_