**Southern Pediatric Clinic, LLC**
**Charlene C. Blache, M.D.**
**Kamela Camon, M.D.**
*Pediatrics and Adolescent Medicine* *www.southernpediatricclinic.com*

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088
Tax: ID: 20-2561935

# New Patient Acceptance Application

Thank you for your interest in establishing care with our practice. To ensure we are the best fit for your child's healthcare needs, please complete the application below. Submission of this form does **not** guarantee acceptance into the practice. Our team will review the information and notify you regarding acceptance.

## Office Policies

### Vaccination Policy:

Our clinic follows the immunization guidelines recommended by the American Academy of Pediatrics (AAP). Vaccinations are an important part of preventive healthcare and help protect children and the community from preventable diseases.

**Do you plan to have your child vaccinated according to recommended pediatric vaccination schedules?**

☐ YES ☐ NO

**Acknowledgment of Clinic Vaccine Policy**

☐ I acknowledge that I have been informed that this clinic follows recommended pediatric vaccination guidelines and agree to comply with the clinic's vaccination policy.

### Georgia Immunization Registry (GRITS) Authorization:

The State of Georgia maintains the Georgia Registry of Immunization Transactions and Services (GRITS), a secure statewide immunization registry used by healthcare providers to record and access immunization information. By signing below, I authorize this clinic and its healthcare providers to access my child's immunization records through GRITS for the purposes of treatment, immunization verification, and continuity of care.

☐ YES, I AUTHORIZE ACCESS TO GRITS

☐ NO, I DO NOT AUTHORIZE ACCESS TO GRITS

### Appointment & No-Show Policy:

Our practice values timely care for all patients. Missed appointments prevent other children from receiving care.

- If you miss your initial new patient appointment, your child will be dismissed from the practice and will not be eligible to reschedule as a new patient.
- After your child has established care, missing two (2) scheduled appointments within a calendar year without proper notice may result in dismissal from the practice.

We ask that you please notify our office as soon as possible if you need to cancel or reschedule an appointment.

☐ I acknowledge and understand the clinic's No-Show Policy.

**Parent/Guardian Policy Acknowledgment**

By signing below, I acknowledge that I have reviewed and understand the policies outlined in this application, including the clinic's vaccination policy, GRITS authorization option, and appointment/no-show policy. I understand that failure to comply with these policies may affect my child's ability to receive care from this practice.

**Parent/Guardian's Signature:** _____ **Date:** _____

**Please flip page over to complete patient information**

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## Patient Information

Parent/Guadian Name: _____ Phone Number: _____
Address: _____City: _____ State: _____ Zip Code _____
Email address: _____
Have you been a previous patient of the practice? □ Yes or □ No
Are you transferring from a local Practice: □ Yes or □ No
If yes, where are you transferring from? _____ Reason for transferring? _____
_____

Medical Insurance: □ Commercial: _____ □ Medicaid: _____ □ Tricare □ Self Pay
(Please provide a copy of your insurance card to the front desk with this application).

How did you hear about us? (Please check one) □ Google □ Patient (Word of Mouth) □ Magazine/Marketing Ad □ Social Media (Facebook/Instagram) □ SPC's Website□ SGMC Staff □SGMC Patient Guide Booklet

| Child's Name: | DOB: | Sex: □ Male or □ Female |
|---|---|---|
| Is your child up to date on vaccines? □ Yes or □ No | If no, why not? _____ | |
| Does your child have any health problems that you are concerned about? _____ | | |
| Is your child currently seeing a Specialist? □ Yes or □ No | If yes, who? _____ | |

**Does your child have a history of any of the following? Please check all that apply.**

| | | | | |
|---|---|---|---|---|
| □ ADHD | □ blood disorders | □ eczema | □ pneumonia | □ other: |
| □ allergies | □ bronchiolitis/RSV | □ febrile seizures | □ psychiatric disorder | _____ |
| □ anemia | □ chronic ear infections | □ heart condition | □ urinary tract infections | _____ |
| □ asthma/wheezing | □ developmental disorder | □ kidney problem | □ vision/eye problems | _____ |

| Child's Name: | DOB: | Sex: □ Male or □ Female |
|---|---|---|
| Is your child up to date on vaccines? □ Yes or □ No | If no, why not? _____ | |
| Does your child have any health problems that you are concerned about? _____ | | |
| Is your child currently seeing a Specialist? □ Yes or □ No | If yes, who? _____ | |

**Does your child have a history of any of the following? Please check all that apply.**

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| □ anemia | □ chronic ear infections | □ heart condition | □ urinary tract infections | _____ |
| □ asthma/wheezing | □ developmental disorder | □ kidney problem | □ vision/eye problems | _____ |

**Parent/Guardian Acknowledgment**

I certify that the information provided above is accurate to the best of my knowledge. I understand that submission of this application does not guarantee acceptance into the practice.

**Parent/Guardian's Signature:** _____ **Date:** _____

**Office Staff Only**

| |
|---|
| UTD on Vaccines □ yes or □ no Previous Pt. □ yes or □ no If yes, comment: _____ _____Practice Manager's Signature: _____ Date: _____ |
| **Provider Only:** □ Accepted □ Denied Provider's Signature: _____ Date: _____ |
| **Front Desk Staff Only:** □ Date Patient Contacted & added to spreadsheet: _____ Staff's Initials: _____ |