PATIENT REGISTRATION FORM

GENERAL INFORMATION

Last Name: First:		DOB:	M / F : (circle one)
Street Address: City: State: Zip:			
Social Security Number:	Home Phone:		Cell Phone:
Occupation:	Employer:		Employer phone:

Due to HIPAA regulations, we are required to have the name of the person we are authorized to discuss your healthcare issues, in the event of a critical matter or emergency. (For patients over 18) ◉ Agree ○ Disagree

Authorized Name	Phone Number	Relationship

INSURANCE INFORMATION

PRIMARY Insurance Carrier:

Subscriber's Name:	Birth date:	Policy #:	Group #:

Patient's relationship to subscriber:

Is patient under 18? ○ Yes ○ No	Guarantor *(responsible for bill):*	Subscriber Age:	Sex: ○ M ○ F

SECONDARY Insurance Carrier *(if applicable):*	Subscriber's name:	Policy#:	Group#:

Patient's relationship to secondary subscriber:

Secondary Subscriber Birth date:	Address (if different):	Home Phone:	Cell Phone:
Is this person a patient here?	○ Yes ○ No	Is this visit due to Worker's Compensation?	○ Yes ○ No

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Home phone:	Cell Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Georgia Urgent Care or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

PHARMACY
NAME: _____
PHONE: _____
ADDRESS OR ZIP CODE: _____

PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____ Date: _____

Please list all medications you are currently taking including any over-the-counter medications.

Medication	Dosage	Reason

Please indicate any drug allergies: Reason for Visit:

Please indicate any health conditions for which you are currently being treated or have ever been treated.

YES	NO	Condition	YES	NO	Condition
		Asthma			High Blood Pressure
		Arthritis			High Cholesterol
		Bleeding Disorder			Kidney Disease
		Cancer			Migraine
		COPD			Musculoskeletal
		Diabetes			Seizures
		Depression/Anxiety			Sickle Cell Disease
		Gastrointestinal			Sleep Disorder
		Heart Disease/Heart Attack			Stroke
		Hepatitis			Thyroid Disease

Please list any surgeries, hospitalization, and/or serious injuries.

Reason/Type	Date	Reason/Type	Date

Any chance you are pregnant? Yes/No

Are you a smoker? Yes/No If yes, how many packs a day? _____

Do you drink alcohol? Daily/Socially/Never

PATIENT AUTHORIZATION

I hereby authorize **Georgia Urgent Care** to render medical care to me during my office visit and to fulfill the orders of my physicians; including consultants, associates, and assistants of the physician's choice. I am financially responsible for the services provided which are to be paid on the day services are rendered. I further acknowledge that I am the owner/dependent of the insurance policy and that the insurance contract is between myself/policyholder and the insurance carrier. **Georgia Urgent Care** has no leverage to obtain payment from my insurance carrier. As such, **Georgia Urgent Care** will appropriately bill my insurance carrier however I will be responsible for all unpaid services due to copays, deductibles, or rejected claims. **Georgia Urgent Care** will attempt to verify insurance coverage at the time of service. Benefit and eligibility information obtained may be inaccurate or incomplete and only the final Explanation of Benefits (EOB) sent from the insurance carrier will stand as the final statement of monies owed. I will be billed (or credited) for any outstanding balances (or overcharges) whereupon I am obliged to make payment within 30 days. I realize that failure to keep this account current may result in **Georgia Urgent Care** being unable to provide continuing medical services.

I acknowledge and agree that **Georgia Urgent Care** and/or vendor including billing and/or collection companies may contact me on the numbers listed below. I further agree that I may be contacted by use of an Automated Telephone Dialing System (ATDS) or prerecorded message. With this consent, **Georgia Urgent Care** may share my Personal Health Information (PHI) including lab and test results, diagnosis, and treatments in the following methods and to the following individuals:

Leave Message? YES/NO Cell: _____ Home: _____

Name: _____ Relationship: _____ Phone Number: _____

I authorize **Georgia Urgent Care** to release medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, treatment, or any other such related information to: My insurance company(ies) or its designated representatives. Any person(s) or entities financially responsible for my care or treatment. Representative or local, state, or federal agencies in accordance with law. Employees or representatives for investigation and defense of any claim or cause of action, actual or potential which may be asserted against **Georgia Urgent Care** or its employees. I have been provided with a Notice of Privacy Practices that provides a more complete description or information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail copy of the revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree with the restrictions requested. I understand I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

_____ _____ _____

Signature of Patient or Legal Guardian *Patient Name (printed)* *Date*