Cumming Family Health Center   Canton Family Health Center   Bartow Family Health Center   Dawsonville Family Health Center   Highlands Medical Plaza

PATIENT INFORMATION AND REGISTRATION RECORD

Last Name: ____

First Name: ______________________________*Middle Initial:* ______

Pharmacy of Choice: ________________________
Address: ___________________________________
Phone: ____________________________________

Street Address: ___________________________________*City:* ________________________ *State:* ________ *Zip:* ___________

Your Email address: ____

_____ *Divorced*   _____*Married*   _____ *Partner*   _____ *Single*
_____*Widow*   _____ *Legally Separated*   _____*Unknown*

Date of Birth: ___________ *Social Security #* ___________________

Sex: *Female* _________ *Male* _________ *Other:* _________

Student: Yes _____ *No* ______   *Employed: Yes* ______ *No*_______

Employer's Name: ____

Employer's Phone #: ______________________________________

Emergency Contact Name: __________________________________

Phone #: _________________*Relationship to Patient:* ____________

Billing Information:

Person Responsible for Payment (Guarantor):

Name: ____

Address: ____

City: _________________ *State:* _______ *Zip:* __________

SS#: __________________ *Date of Birth:* ______________

Phone #: ____

Relationship to Patient: _____________________________

Home Phone: ______________________________________ ***Cell Phone***_______________________________________

Telephone Disclosure: You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail addresses you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Please mark if applicable:

*Does this patient have a Care Giver? Yes*_____ *No* _____
Name: ____
Relationship: ______________________________________
Are you Disabled? Yes _______ *No* _______
Do you have an Advanced Directive for end of life care? Yes ____ *No* ____

Have you served in the Armed Forces? Yes ____ *No* _____
Are you Homeless? Yes _________ *No* __________
*Are you a Seasonal Worker? Yes*_________ *No*________
Are you a Migrant Worker? Yes _______ *No* ________
Do you need a Translator? Yes _____ *No* _____

Please mark all Races:

American Indian/Alaska Native _____
Asian _____
Black/African American _____
Other Pacific Islander _____
Native Hawaiian _____
White _____
Refuse to report _____

Please mark one Ethnicity:

Non-Hispanic _____
Hispanic _____
Refuse to Report _____

Insurance Information

Yes, I have Medical Insurance: ____________________ No, I do not have Medical Insurance: ________________________
Primary Insured Holder Name: _______________________________ DOB: ___________ Social Security # _________________
I understand I am required to provide a copy of my Medical Insurance card and proof of coverage within my insurance plans time frame or I will be responsible for the full charges of my appointments. ***Initial _________***

PLEASE NOTE: *Agencies that provide funding to Georgia Highlands Medical Services (GHMS) require that we obtain the information below. It is through funding from these agencies that GHMS is able to deliver cost-effective, meaningful care to our patients. Information you provide here* ***WILL NOT*** *be shared with any other agency.*

Which category best describes your current yearly family income?
_____<$10,000 _____$10,001-14,999 _____$15,000-19,999 _____$20,000-29,999
_____$30,000-49,999 _____$50,000-79,999 _____$OVER $80,000

The number of family members living in the home that are supported by your yearly income? ___________

Sliding Fee Information

We offer a sliding fee scale for qualified patients. Are you interested in applying for our sliding fee scale?
_____ Yes, I am interested in applying for the sliding fee scale. I would like an application and understand I must now provide the required documentation to qualify for the sliding fee scale. ***Initial ________***
_____No, I am not interested in applying for the sliding fee scale. I understand I can apply at a later date. (A separate application and verification of family size and income is required for this service). ***Initial ________***

Are any members of your family ALREADY patients at Georgia Highlands Medical Services? Yes _____ No _____
If yes, please list the names and dates of birth for each.

Name:	*Date of Birth:*

Payment and medical treatment consent

Consent for Treatment: I hereby consent to any treatments, diagnostic tests or studies necessary by any provider or clinical staff member of Georgia Highlands Medical Services. *I ALSO AUTHORIZE THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, CERTIFIED NURSE MIDWIFE OR LICENSED CLINICAL SOCIAL WORKER TO GIVE ME/MY DEPENDENT REASONABLE AND PROPER MEDICAL CARE BY TODAY'S STANDARDS*. Georgia Highlands Medical Services is an entity that participates in Title X Services. I also authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/Aids confidential information required in the processing of an insurance claim, or any medical information that is needed for utilization review or quality assurance activities. I hereby authorize my insurance or Medicare benefits are paid directly to Georgia Highlands Medical Services. I also understand that any portion that is not covered by Insurance is my responsibility to pay. Payment is expected at time of service and Georgia Highlands Medical Services may use any means deemed necessary to collect a debt. A photocopy of this authorization shall be considered as effective and valid as the original. All above information is correct, and this will remain in effect until revoked by me in writing.

Patient's Signature/Representative: ____ Date: _________________

Relationship if other than Patient: ____