



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

**Highlands Pharmacy:** \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_

**PATIENT INFORMATION AND REGISTRATION RECORD**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

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. You also authorize that we leave a recorded message on the phone numbers provided above regarding appointments or results.

**Please mark if applicable:**

Does this patient have a Care Giver? Yes \_\_\_\_\_ No \_\_\_\_\_      Have you served in the Armed Forces? Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_      Homeless? Yes \_\_\_\_\_ No \_\_\_\_\_

Relationship: \_\_\_\_\_      Are you a Temporary Seasonal Agriculture Worker in our area? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you Disabled? Yes \_\_\_\_\_ No \_\_\_\_\_      Are you a Temporary Migrant Agriculture Worker in our area? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have an Advanced Directive for end of life care? Yes \_\_\_\_\_ No \_\_\_\_\_      Do you need a Translator? Yes \_\_\_\_\_ No \_\_\_\_\_

**Please mark all Race:**

White \_\_\_\_\_

Black/African American \_\_\_\_\_

Asian \_\_\_\_\_

Decline to Specify \_\_\_\_\_

**Please mark one Ethnicities:**

Non-Hispanic \_\_\_\_\_

Hispanic \_\_\_\_\_

Decline to Specify \_\_\_\_\_



**Payment and Medical Treatment Consent**

**Consent for Treatment:** I hereby consent to any treatments, diagnostic tests to include but not limited to HIV Testing 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 and a patient can receive Confidential & Voluntary Family Planning Services if requested. Adolescents can consent for themselves to receive Family Planning 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.

If you choose to use mailing option for your prescriptions through our pharmacy, you give us the consent to mail it to the address provided by you.

I understand that the 2019 novel coronavirus, which causes the disease Covid-19, has been declared a pandemic by the World Health Organization, is extremely contagious, and is believed to be spread by person-to-person contact. I recognize that the staff of Georgia Highlands Medical Services has put in place reasonable preventative measures aimed at reducing the spread of Covid-19. Organizational protocols that pertain to the evaluation of patients are in a state of rapid change based on the information released by regulatory bodies including CDC and other Federal and State Organizations. Most current protocols are followed during my care at Georgia Highlands Medical Services.

**Patient's Signature/Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship if other than Patient:** \_\_\_\_\_