

INFECTIOUS DISEASE SERVICES OF GEORGIA, P.C.
ROSWELL • CUMMING • JOHNS CREEK

REGISTRATION FORM

Information provided on this form is considered protect health information and is protected by Federal and State Privacy Regulations.

PLEASE PRINT		PATIENT INFORMATION			
Today's Date:		Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other (Specify) _____			
Last Name:		First Name:	Mid. In.:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Date of Birth:
Former Name:		Social Security No.:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status : <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Street Address:			Apt. No.	Home Phone:	
City:		State:	Zip:	Cell Phone:	
Occupation:		Employer:		Work Phone:	
Preferred Method of Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Other – Specify: _____					
Ethnicity: (select one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Race: (select one or more from the following) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American			
REFERRAL/PRIMARY CARE PHYSICIAN					
Reason for Referral to this Clinic:					
Referred to Clinic By: (check one) <input type="checkbox"/> Clinician <input type="checkbox"/> Physician <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other _____					
If Referred by Physician – Physician's Name:				Phone: () -	
Primary Care Physician (if different from above):		Office Location:		Phone: () -	
INSURANCE INFORMATION					
Insurance Company:			Effective Date:	Phone: () -	
Policy Holder's Name:		Employer:		Date of Birth	
Policy Number:		Group Number:		I.D.	
Name of Secondary Insurance (if applicable):			Effective Date:	Phone: () -	
Secondary Ins. - Policy Holder's Name:		Employer:		Date of Birth	
Secondary Ins. Policy Number:		Secondary Ins. Group Number:		Secondary Ins. I.D.	

Patient Name: _____

Date of Birth: _____

SUMMARY OF CURRENT TREATMENT CONSENT FOR TREATMENT

PREFERRED PHARMACY			
Name:		Phone Number:	
Address / Intersection:			City:
CURRENT TREATMENT			
List the names of all current physicians and the treatment you are receiving.			
Physician Name	Phone/Contact Info	Reason for Treatment	
IN CASE OF EMERGENCY			
Name of Local Friend or Relative:	Relationship to Patient:	Phone: () -	2 nd Phone: () -
AUTHORIZATION FOR TREATMENT			
I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated provider.			
ASSIGNMENT OF INSURANCE BENEFITS			
I hereby assign payment directly to Infectious Disease Services of Georgia, P.C. for services covered by insurance or other health benefit plans.			
AUTHORIZATION FOR RELEASE OF INFORMATION			
I authorize Infectious Disease Services of Georgia, P.C. to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV/AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to other healthcare providers to whom I have been referred for healthcare services or who provides consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of this authorization is as valid as the original.			
_____		_____	
<i>Patient/Guardian Signature</i>		<i>Date</i>	

<i>Relationship if Other than Patient</i>			