Print

INFORMATION SHEET

DATE_____

Patient Name _____
LAST FIRST MIDDLE

SS# _____ Age _____ Home Phone _____
area code and number

Sex ☐☐ Birthdate _____ Marital Status ☐/☐/☐/☐ Work Phone_____
circle one Month/Day/Year circle one

Race _____If child, Parent's name _____

Address _____
Street Box # City State Zip

Employer_____ Is this worker's compensation? _____

Primary Insurance Coverage_____ PPO? _____

Policy Holder Name _____ _____Relation to patient _____

If thru employer, employer's name _____

Policy or contract number _____ Group Number_____

Secondary Insurance Coverage _____PPO?_____

Policy Holder Name_____ Relation to patient _____

If thru employer, employer's name _____

Policy or contract number _____Group Number _____

Third Insurance Coverage _____ PPO?_____

Policy Holder Name _____Relation to patient _____

If thru employer, employer's name _____

Policy or contract number _____Group Number _____

Were you referred to us by another physician? _____ If so, Physician's name _____

If married, spouse's name_____ Spouse's employer_____

Spouse's SS# _____Spouse's Date of Birth_____

Are you allergic to any medications?_____ If so, what? _____

In case of emergency please list number other than the numbers above _____

In case of hospitalization, please sign the authorization below.

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO INSURANCE CARRIERS.

_____

PATIENTS SIGNITURE IF CHILD PARENTAL SIGNITURE

Dear Patient,

Print

We would like to explain our insurance and pay policy.

Payment is expected at the time of service. At the time of payment you will be given an insurance copy that will contain all information needed to file with your insurance carrier.

If we participate with your plan, we will file with your carrier. All co-pays, deductibles and patient portions will be due at the time of service.

If your account is placed with a collection agency for nonpayment, you will be responsible for any collection fees in addition to the balance being placed for collection.

If you have any questions, please ask the receptionist.

PATIENT'S SIGNATURE

IF CHILD, RESPONSIBLE PARTY

MEDICAL HISTORY

Are you allergic to any foods or drugs? If so, list _____

Are you now taking any prescribed medicines? If yes, list medications and doctor's name who prescribed medication

For what condition are you taking these medicines? _____

Do you or your family have, or ever had arthritis, diabetes, cancer, TB, high blood pressure, heart trouble, or epilepsy? _____ If yes, please list _____

Do you smoke? _____ Smoke _____ packs per day.

Do you drink? _____ Drink _____ per week.

List any time you have ever been hospitalized in your life.

Date	Hospital	Doctor's Name	Reason for hospitalization

Date

Patient's Signature / If child, parents

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DALTON FAMILY PRACTICE, P.C
COMPREHENSIVE HEALTHCARE

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, there will be a revised copy available in our waiting room.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name _____

Patient/Responsible Party Signature _____

Date _____

Print

DALTON FAMELY PRACTICE, P.C.
COMPREHENSIVE HEALTHCARE

FAMILY HEALTH INFORMATION ACCESS FORM

Date _____

Patient Name: _____ ID# _____

I _____ , authorize Dalton Family Practice to release any of my individually identifiable health information to:

_____	_____	_____
Name	Relationship	Number
_____	_____	_____
Name	Relationship	Number
_____	_____	_____
Name	Relationship	Number

I understand that if the party(s) authorized to receive this information are not a health plan or a health care provider, the released information may be redisclosed and may no longer be protected by federal privacy regulations.

I understand that this authorization will remain in effect until I revoke it in writing to Dalton Family Practice, 1114 Professional Blvd., Dalton, Ga. 30720. Attn: Privacy Officer.

_____
Signature of patient or patient's legal representative

1114 PROFESSIONAL BLVD. • DALTON, GEORGIA 30720 • PHONE (706) 278-0138 • FAX (706) 226-6882
William L. McDaniel, Jr., M.D. • Robert W. Simmons, M.D. • John S. Antalis, M.D. • Brad DeLay, M.D. Raymond A. Bedgood. M.D.

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HOW DID YOU HEAR ABOUT DALTON FAMILY PRACTICE?

_____

ARE ANY MEMBERS OF YOUR FAMILY A PATIENT HERE?

YES ___☐___ NO ___☐___

IF YES, LIST NAMES AND RELATIONSHIP TO YOU.

_____

_____

PLEASE LIST YOUR MEDICAL CONDITIONS:

_____

_____

LAST DOCTOR THAT TREATED YOU AND WHEN?

_____

PREVIOUS SURGERIES:_____

_____

PREVIOUS HOSPITALIZATIONS:_____

_____

WHAT IS YOUR REASON FOR CHANGING DOCTORS OR SEEKING A NEW PHYSICIAN?

_____

DO YOU UNDERSTAND AND AGREE THAT ANY COPAYS ARE DUE WHEN TREATED AND ANY BALANCE DUE BY YOU AFTER YOUR INSURANCE IS DUE IN FULL WITH THE 1ST STATEMENT?

_____ _____

SIGNATURE DATE