Dear Patient,

Let us take this opportunity to thank you for choosing Dalton Family Practice to provide your healthcare needs.

Please fill out the enclosed paperwork, including a list of all medications and copies of front and back of insurance cards.

You can return the forms back to us by any of the following ways:

Mail to:

Dalton Family Practice

1114 Professional Blvd, Dalton, GA 30720 or

Fax to:

706-226-6586 or

Email to any of the following at:

khensley@daltonfamilypractice.com

clafferty@daltonfamilypractice.com

If you have any questions, we invite you to call us at 706-278-0138 and we will be happy to assist you.

Once again, thank you for your consideration.

Sincerely,

The Physicians and Staff at Dalton Family Practice

Dalton Family PRACTICE

| | |
|---|---|
| Name: | Date of Birth: / / |
| Cell number: ( ) | Email: |
| Ethnicity: Not Hispanic Hispanic | |
| Race: African American/Black American Indian Asian White Other | |
| Employer: | Work Phone: ( ) |
| Employment Status: Full-time Part-time Retired Student Other | |
| Name of Emergency Contact: | |
| Relationship to Emergency Contact: Spouse Parent Child Other | |
| Emergency Contact Numbers: | Home: ( ) |
| Cell: ( ) | Work: ( ) |

Dalton Family PRACTICE

Date:

| | | |
|---|---|---|
| Patient Name: Last First Middle | | |
| SS# | Age | Sex M F |
| Date of Birth / / | Marital Status S M W D | Race |
| Home ( ) | Cell ( ) | Work ( ) |
| Address: | | |
| City: | State: | ZIP: |

| | |
|---|---|
| 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<br>contract number | Group<br>Number |
| Third<br>Insurance<br>Coverage | PPO? |
| Policy<br>Holder<br>Name | Relation<br>to Patient |
| If thru employer,<br>employer's name | |
| Policy or<br>contract number | Group<br>Number |
| Were you referred<br>by another physician? | If so,<br>physician's name |
| If married, spouse's name | Spouse's employer |
| Spouse's SS# | Spouse's Date of Birth |
| Are you allergic to any medication? Y N | If so, what? |
| In case of emergency,<br>please list number other<br>than 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.

PATIENT'S SIGNATURE IF CHILD, PARENTAL SIGNATURE

| | |
|---|---|
| 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? | |
| 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 first statement? | YES NO |

SIGNATURE DATE

Dear Patient,

We would like to explain our insurance and pay policy.

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

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 questions, please ask the receptionist.

PATIENT'S SIGNATURE IF CHILD, RESPONSIBLE PARTY

| MEDICAL HISTORY | |
|---|---|
| Are you allergic to any food 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? | YES NO |
| If yes, please list: | |
| Do you smoke? YES NO | If yes, I smoke packs per day |
| Do you drink? YES NO | If yes, I drink drinks per week |

| List any time you have ever been hospitalized in your life | | | |
|---|---|---|---|
| Date | Hospital | Doctor's Name | Reason for hospitalization |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PATIENT'S SIGNATURE DATE

IF CHILD, PARENT'S SIGNATURE


## 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


**FAMILY HEALTH INFORMATION ACCESS FORM**

_____
Date

_____

Patient Name ID#

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

_____

Name Relationship Phone

_____

Name Relationship Phone

_____

Name Relationship Phone

I understand, if the party/parties 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 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