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 all forms to the two emails below:

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 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 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 medication? Y N	If so, what?
In case of emergency, please list number other 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