NEW UPDATE

ADULT PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION

NAME ______________________ AGE ______ DATE OF BIRTH ______________

SS#______________ ( ) MALE ( ) FEMALE MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow

ADDRESS ______________________ CITY __________ STATE ______ ZIP ________

HOME # ______________ WORK # ______________ CELL # ______________

RACE__________ ☐ Decline to Specify LANGUAGE: __________ ETHNICITY: ☐ Hispanic or Latino ☐ Unknown ☐ Not Hispanic or Latino ☐ Decline to Specify

EMPLOYER/SCHOOL ______________________ ADDRESS______________________

EMAIL ADDRESS____

AUTHORIZATION TO RELEASE TEST RESULTS / CONFIDENTIAL INFORMATION

MAY WE LEAVE CONFIDENTIAL MESSAGES/TESTS RESULTS ON YOUR: ☐ HOME # ☐ WORK / DAY # ☐ CELL #

PREFERENCE FOR APPOINTMENT REMINDERS: ☐ VOICEMAIL ☐ TEXT MESSAGE ☐ EMAIL

RESPONSIBLE PARTY (if different than above)

NAME ______________________________ DATE OF BIRTH ______________

ADDRESS______________________ CITY__________ STATE______ ZIP________

HOME #______________ WORK # ______________ CELL # ______________

SS#______________ ☐ MALE ☐ FEMALE LANGUAGE______________

PERSON TO NOTIFY IN CASE OF EMERGENCY

PRIMARY EMERGENCY CONTACT: ______________________ PHONE: ______________

SECONDARY EMERGENCY CONTACT: ______________________ PHONE: ______________

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:			POLICY # :
NAME OF INSURED	SSN#	BIRTHDATE	GROUP# :
RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT ☐ OTHER			EFFECTIVE DATE

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE:			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT ☐ OTHER			EFFECTIVE DATE

______________________________ ______________________

PATIENT SIGNATURE **DATE**

Adult Primary Care GMG
575 Professional Drive Suite 510
Lawrenceville Ga. 30046
(P) 770-513-2072 (F) 770 513-7986
Alt. Fax. 678 638 1148

Patient Communication Consent Form

I agree to allow Adult Primary Care to contact me via the contact methods below regarding my private health information, evaluations and treatments. I authorize Adult Primary Care staff to leave messages for me when there is no answer by phone.

Communication Method	Number or Address	Message OK (Yes or No)	
_______ Home Phone	______________________	□ Yes	□ No
_______ Cell Phone	______________________	□ Yes	□ No
_______ Work / Other Phone	______________________	□ Yes	□ No
_______ Text Message (appt. reminders)	______________________	□ Yes	□ No
_______ Email Message	______________________	□ Yes	□ No

I authorize Adult Primary Care staff to discuss my health information (which may include history, diagnosis, Lab and test results, treatment and other health information) with the contacts listed below.

Name	Relationship to Patient	Contact Information

My signature below acknowledges that I understand my rights under the HIPPA law and that a copy has been made available to me. I understand the information I have listed on this consent form. I understand the risks associated with the different methods of communication, including and especially e-mail and texting. I consent to the conditions, restrictions and patient responsibilities in relation to Adult Primary Care's hours of operations.

** ***I have a right to OPT* OUT of ANY communication available to me**. *I understand if I choose to OPT OUT that I will not receive appointment reminders. In the event that I do not answer a call from a member of the Adult Primary Care Staff attempts to reach me no messages will be left and I will be responsible for contacting the office.*

________ **OPT OUT** ***I choose to OPT OUT of ANY and ALL communication and messaging. I am aware this may delay communication with Adult Primary Care and I accept the responsibility regarding this decision.***

Patient Signature: ______________________________ **Date:**______________________

Please remember to request a blank form to update information should contact information (numbers or email's change)
This will be updated yearly unless requested by patient to update more frequently.