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

REGISTRATION FORM

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

PLEASE PRINT	**PATIENT INFORMATION**			
Today's Date:	Please Identify Your Primary or Preferred Language: ☐ English ☐ Other (Specify) _____			
Last Name:	First Name:	Mid. In.:	☐Mr. ☐Mrs. ☐Miss ☐Ms.	Date of Birth:
Former Name:	Social Security No.:	Sex: ☐ M ☐ F	Marital Status: ☐Single ☐Married ☐Widow ☐Divorced ☐Separated	
Street Address:	Apt. No.	Home Phone:		
City:	State:	Zip:	Cell Phone:	
Occupation:	Employer:	Work Phone:		
Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other:				
Used only to allow patient login to Electronic Record - Patient Portal Email Address:				

ENTER A SELECTION FOR BOTH RACE AND ETHNICITY

Race: (select one or more from the following)		Ethnicity: (select one)
☐ American Indian or Alaska Native	☐ Asian	☐Hispanic or Latino
☐ Black or African American	☐ White	☐Not Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ Decline	☐ Decline

REFERRAL/PRIMARY CARE PHYSICIAN

Reason for Referral to this Clinic:		
Referred to Clinic By: (check one) ☐ Clinician ☐ Physician ☐ Family Member ☐ Friend ☐ 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): «InsuranceName1»		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.

Continued

Patient Name:	Date of Birth:

PREFERRED PHARMACY

Pharmacy Name:	Phone Number:
Address:	City:

CURRENT TREATMENT

List the names of all current physicians and the treatment you are receiving.

Physician Name	Phone/Contact Info	Reason for Treatment

Do you have an Advanced Directive? ___yes ___no If yes, please provide a copy for your health record.
Check all that apply: ___Do Not Resuscitate ___Living Will ___Power of Attorney

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Phone:	2nd 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.

_____ _____

Patient/Guardian Signature Date

_____

Relationship if Other than Patient

September, 2011
Update – 10/2011; 12/13; 6/2014; 10/2014; 04/2017