NORTH FULTON INTERNAL MEDICINE GROUP, P.C.

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WELCOME

Thank you for choosing our office! We will strive to provide the best possible health care. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us ~ we are happy to help!

1. PERSONAL PATIENT INFORMATION

DATE: _____/____/_____

NAME: _____ BIRTH DATE: _____/____/_____
ADDRESS: _____ S.S. NUMBER: _____
_____ FEMALE _____ MALE _____
_____ MARITAL STATUS: _____
HOME PHONE: (____) _____ WORK PHONE: (____) _____
EMPLOYER: _____ CELL PHONE: (____) _____
WORK ADDRESS: _____ EMAIL ADDRESS: _____
_____ OCCUPATION: _____
HOW SHOULD WE ADDRESS YOU? _____
REASON FOR VISIT: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
A FAMILY MEMBER OR FRIEND: _____
ANOTHER DOCTOR OR PROVIDER: _____
VIA THE INTERNET: ❑OUR WEBSITE ❑GOOGLE ADVERTISEMENT ❑

IF PATIENT IS A MINOR:
MOTHER'S NAME _____ FATHER _____
WORK PHONE: (____) _____ WORK PHONE:(____) _____

2. SPOUSE INFORMATION

NAME: _____ OCCUPATION: _____
EMPLOYER: _____ BUSINESS PHONE: _____

3. NEAREST RELATIVE OR RESPONSIBLE FRIEND WHO CAN BE CONTACTED IF NEEDED (OTHER THAN SPOUSE)

NAME: _____ CELL #: _____ WORK #: _____

4. CONSENT TO DISCLOSE PRIVATE HEALTHCARE INFORMATION

Please initial all that apply:

_____ I consent to receiving communication regarding my care via email.

_____ I consent to have detailed messages left on my voicemail at home.

_____ I consent to have detailed messages left on my voicemail at work.

_____ I consent to have detailed messages left on my cellular voicemail.

_____ I consent to have my care discussed with my spouse.

_____ I consent to have my care discussed with my immediate family members.

_____ I consent to have my care discussed with _____.

_____ I do not consent to have my care discussed with anyone other than myself.

_____ I have been given the opportunity to review NFIMG's privacy practices and am aware that I may revoke the above designation(s) at any time via written request.

5. AUTHORIZATION

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care plans. While we are pleased to be able to provide this service, it is impossible for us to keep track of the many requirements of these plans, as each one has different stipulations regarding how, when and where services may be performed. Please help by informing us of any special requirements within your insurance policy regarding procedures or lab work that may be ordered or performed. Some insurance companies have HMO, PPO, POS and indemnity plans. It is likely that our doctors may only participate in one of these plans and not all of them. Insurance cards do not always clearly identify which type of plan you have, making it difficult for us to be sure we participate with your plan. If it is unclear as to whether or not we participate with your plan, we ask that you pay at the time of service and we will be happy to give you the forms you will need to file with your insurance company.

It is your responsibility to verify if your particular plan covers annual or routine exams. If your appointment is for a routine annual exam, we must bill it as a routine exam and not as an "illness", as you may have had done in the past. In the event your insurance company deems that a NON-COVERED service (office visit or lab tests) has been performed, it will be necessary for us to bill you directly. It is possible that your insurance company will make this determination and the lab will bill you directly. We are always glad to assist you in communicating the diagnosis related to any tests performed in the lab. Services may be considered non-covered for a variety of reasons, such as expired coverage, a non-participating physician, or the tests ordered or services performed are not covered under your insurance policy.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me unless I have already paid it. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY. THE INFORMATION YOU HAVE PROVIDED WILL HELP US SERVE YOUR HEALTHCARE MORE EFFECTIVELY AND EFFICIENTLY. IF YOU HAVE ANY QUESTIONS AT ANYTIME, PLEASE ASK ~ WE ARE ALWAYS HAPPY TO HELP.