PATIENT REGISTRATION (PLEASE PRINT CLEARLY)

NAME_____
LAST FIRST MI

ADDRESS_____

CITY/STATE/ZIP CODE: _____

SEX _____RACE:_____MARITAL STATUS:_____BIRTHDATE_____SS#_____

EMAIL ADDRESS_____

PLACE OF EMPLOYMENT _____

RESPONSIBLE PARTY_____RELATIONSHIP TO PATIENT:_____

ADDRESS_____
STREET CITY STATE ZIP

HOME PHONE_____WORK PHONE_____CELL PHONE_____

FAMILY MEDICINE ASSOCIATES OF AUGUSTA HAS THE RIGHT TO REVIEW AND OBTAIN MY PAST MEDICATION HISTORY.

PHARMACY NAME: LOCATION:

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____IF SO, WHICH MEDICATIONS? _____

_____

IN CASE OF EMERGENCY (NOT LIVING WITH):_____PHONE_____

REFERRED BY_____

COPIES OF INSURANCE CARD AND DRIVERS LICENSE WILL BE MADE UPON EACH VISIT FOR YOUR FILE.

WE ARE LEGALLY BOUND TO COLLECT YOUR COPAY AT TIME OF EACH VISIT. IF YOU ARE UNABLE TO PAY YOUR COPAY, WE WILL NEED TO RESCHEDULE YOUR VISIT FOR ANOTHER DATE.

-Over-

_____ (OPTIONAL) MAY BE CONTACTED BY PHONE, EMAIL, TEXT, OR MAIL REGARDING MY TREATMENT WITH FAMILY MEDICINE ASSOCIATES OF AUGUSTA. THIS INCLUDES BUT NOT LIMITED TO APPOINTMENT REMINDERS, LAB RESULTS, XRAY RESULTS, AND REFERRALS ETC…

PLEASE SIGN BELOW IF YOU WISH **NOT** TO BE CONTACTED BY PHONE, EMAIL, TEXT, OR MAIL REGARDING YOUR TREATMENT WITH FAMILY MEDICINE ASSOCIATES OF AUGUSTA.

THIS AUTHORIZATION IS IN EFFECT AS OF:

DATE_____ SIGNATURE_____

MEDICARE LIFETIME ASSIGNMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO FAMILY MEDICINE ASSOCIATES OF AUGUSTA FOR ANY SERVICES FURNISHED TO ME BY THIS PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES.

NOTICE OF PRIVACY PRACTICES

I HAVE REVIEWED AND BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM FAMILY MEDICINE ASSOCIATES OF AUGUSTA.

THIS AUTHORIZATION IS IN EFFECT AS OF:

DATE_____ SIGNATURE_____

Revised 04.04.2014