Rockdale Family Practice, P.C.
2020 Honey Creek Parkway S.E, Conyers, GA
Main: (770) 929-0813 Fax: (770) 922-8653

Patient Information:

Name: ____ **Date of Birth**: ____ /____/_____
(First) (Middle Initial) (Last)

Mailing Address: ____

City, State, Zip: ____________________________________ **Social Security #**: ______-______-______

Home Phone #: ( ) ________-__________ **Cell Phone #**: ( ) ________-__________

OK to leave message: Home ○ Yes ○ No **OK to leave message:** Cell ○ Yes ○ No

Email Address: ____ **Online chart access**: ○ Yes ○ No

Work Status: ○ Employed ○ Student ○ Unemployed ○ Retired ○ Disabled

Employer: __________________________________ **Occupation**: __________________________

Work Phone #: ( ) ________-__________ **ext.** _______

Gender: ○ Male ○ Female **Marital Status**: ○ Single ○ Married ○ Divorced ○ Widowed

Race: ○ White ○ Black or African American ○ American Indian or Alaska Native ○ Asian ○ Pacific Islander
○ Decline to Answer

Ethnicity: ○ Non-Hispanic ○ Hispanic or Latino ○ Decline to Answer **Preferred Language:** ________________

Spouse / Parent / Guardian Information:

Name: ________________________________ **Phone Number:** ( ) ________-_____________

Address: ______________________________ **Relationship to Patient:** _________________________

Emergency Contact Information:

Name: ________________________________ **Phone Number:** ( ) ________-______________

Relationship to Patient: ___________________________

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PLEASE NOTE: It is patient responsibility to coordinate benefits by contacting and informing insurance carriers of other health insurance policies to ensure claims are filed accurately.

Primary Insurance:

Insurance Carrier: ____

Policyholder's Name: ____

Policyholder's Date of Birth: ______/______/______

Relationship to Patient: ____

Insured Party ID #: ____

Secondary Insurance:

Insurance Carrier: ____

Policyholder's Name: ____

Policyholder's Date of Birth: ______/______/______

Relationship to Patient: ____

Insured Party ID #: ____

Consent to Treatment: I hereby request and voluntarily authorize Rockdale Family Practice, P.C. and its designated physicians and staff to provide and perform such medical care, tests, procedures, medications, and other services as deemed advisable or necessary in my diagnosis and treatment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the results of the treatments, examinations or medical care at Rockdale Family Practice. I understand that this authorization includes treatment of minors who may not be accompanied by a parent or guardian unless I have otherwise stated.

I attest that the information provided is correct and have read and understand the policies of Rockdale Family Practice, and accept my responsibility as stated in those policies. I hereby authorize release of information necessary for my insurance carrier to process my claim. I hereby allow the clinical staff of Rockdale Family Practice to view my medication history from external sources.

Signature of Patient: ___________________________________ **Guardian:** ________________________________

Today's Date: ______/______/______ **Relationship to Patient:** ___________________