**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 #**: _____ - _____ - _____

**Primary Phone #**: ( ) _____ - _____ **Secondary Phone #**: ( ) _____ - _____

**OK to leave message**: ○ Primary ○ Secondary **Email Address:** _____

**Preferred Method of Contact for Results and Referrals:** ○ MyChart Patient Portal ○ Mail

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

**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:** _____

**Work Status**: ○ Employed ○ Student ○ Unemployed ○ Retired ○ Disabled **Occupation**: _____

**Employer**: _____ **Work Phone #**: ( ) _____-_____ **ext.** _____

**Spouse / Parent / Guardian Information:**

**Name:** _____ **Phone Number:** ( ) _____-_____

**Address:** _____ **Relationship to Patient:** _____

**Emergency Contact Information:**

**Name:** _____ **Phone Number:** ( ) _____-_____

**Relationship to Patient:** _____

**Guarantor Account/ Responsible Party:**

**Name:** _____ **Date of Birth:** ___ / ___ / ___ **Relationship to Patient:** _____

**Address:** _____

**Primary Care Physician:** ○ **Mohamed Kassam, M.D.** ○ **Mary Jane Kassam, M.D.** ○ **Nadeem Hoodbhoy, M.D.** ○ **Nayeem Akmal, M.D.** ○ **Indira Asser, M.D.**

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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.**

**Acknowledgement of Receipt of Notice of Privacy Practices:** I acknowledge that I have been provided the ROCKDALE FAMILY PRACTICE Notice of Privacy Practice ("Notice"):

- Rockdale Family Practice will also use and share my health information as required/ permitted by law.
- I consent to Rockdale Family Practice using and disclosing my treatment records maintained by Rockdale Family Practice for the purposes detailed in ROCKDALE FAMILY PRACTICE Notice of Privacy Practices.

**Signature of Patient:** _____ **Guardian:** _____

**Today's Date:** _____/_____/_____ **Relationship to Patient:** _____

Revised January 2018