Rockdale Family Practice, P.C.

2020 Honey Creek Parkway S.E, Conyers, GA

Main: (770) 929-0813 Fax: (770) 922-8653

2015 Patient Registration

Patient Information: Today's Date: ____/____/_____

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

Mailing Address: _____

City, State, Zip: _____ Social Security #: _____-_____-_____

Email Address: _____

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

O Employed O Student O Unemployed O Retired

Employer: _____ Occupation: _____

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

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

Ethnicity: O Non-Hispanic O Hispanic or Latino O 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:_____

Revised December 2014

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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 #: _____

Financial Policies: I understand and agree that I will be responsible for any balances not covered by my insurance company. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (35%), attorney fees, court costs, etc. Any NSF/returned checks will be assessed a $30.00 fee. Failure to cancel an appointment within 24 hours will result in a no show fee that is the sole responsibility of the patient. A $25.00 fee will be charged for any missed clinical appointments, and a $50.00 fee will be charged for missed annual physical appointments and diagnostic testing. A missed appointment is considered as such if you fail to contact our office and give a 24-hour notice of cancelling an appointment, or if you fail to show for your previously scheduled appointment.

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.

Signature of Patient: _____ Guardian: _____

Date: _____/_____/_____

Revised December 2014