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

Patient Registration Forms

DEMOGRAPHIC INFORMATION

Full legal name: _____ **Sex:** ☐ Male ☐ Female **Date of Birth:** _____/_____/_____
(First) (Middle) (Last)

Social Security Number: _____-_____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity/ Race: ☐ Hispanic/ Latino ☐ Asian ☐ Black/ African Amer ☐ White ☐ Other _____ **Preferred Language:** _____

Mailing Address: _____

City, State, Zip _____ **Email:** _____

Home Phone: ( ) _____ - _____ **Cell Phone:** ( ) _____ - _____ **Primary Phone:** ☐Home ☐Cell

Employment Status: ☐Full-Time ☐Part-Time ☐Self-employed ☐Active duty ☐Student ☐Retired ☐Disabled ☐Not employed

Employer: _____ **Work Phone:** ( ) _____ - _____ Ext. _____

COMMUNICATION PREFRENCES

How Would You Like to Receive Appointment Reminders? ☐Phone ☐Text Message ☐ Email ☐MyChart Patient Portal
May we leave detailed voicemails? ☐Yes ☐No
Preferred method of contact for billing/ financial purposes: ☐MyChart Patient Portal ☐ Email ☐Phone

EMERGENCY CONTACT

Name: _____ **Relationship to patient**: _____ **Phone:** ( ) _____ - _____

GUARANTOR (responsible party for minor or incapacitated adult) ☐ Self

Name: _____ **Date of Birth:** _____/_____/_____ **Social Security Number:** _____-_____-_____

Sex: ☐ Male ☐ Female **Relation to patient:** ☐Mother ☐Father ☐Legal Guardian ☐Other: _____ **Phone:** ( ) _____ - _____

Mailing address- if different from patient: _____ **City:** _____**State:** _____ **Zip:** _____

INSURANCE INFORMATION

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

☐ **Self-Pay (no insurance)**

	Primary Insurance	**Secondary Insurance**
Insurance Carrier:	_____	_____
Insured Party ID #:	_____	_____
Subscriber's Name:	_____	_____
Subscriber's Date of Birth:	____/____/____	____/____/____
Patient relation to subscriber:	☐Self ☐Spouse ☐Child ☐Other: _____	☐Self ☐Spouse ☐Child ☐Other: _____

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.

Patient Signature: _____ **Guardian:** _____

Date: _____/ _____/ _____ **Relationship to Patient:** _____