PATIENT INFORMATION

PATIENT INFORMATION – Please Print

Last Name _____
First Name _____
Preferred Name _____
Middle _____ Suffix _____
Former Last name _____
Gender [ ] Male [ ] Female
Birth Date _____
SS Number _____
Address _____
Zip Code _____
City _____ State _____
Home Phone _____
Cell Phone _____
Work Phone _____
e-mail _____
I prefer to be contacted by: [ ] e-mail [ ] Text Message
[ ] Home Phone [ ] Work Phone [ ] Cell Phone
[ ] OK to leave message [ ] Do NOT leave a message
[ ] Don't call Home Number [ ] Don't call Work
[ ] Other _____

Provider _____
Pharmacy _____
Language:
[ ] English [ ] Spanish
[ ] Other _____
Race [ ] American Indian/Alaskan Native [ ] Asian
[ ] Black/African American [ ] Native Hawaiian
[ ] Other Pacific Islander [ ] White
[ ] Other _____
Ethnicity [ ] Hispanic/Latino [ ] Not Hispanic
[ ] Other _____

Marital Status [ ] Married [ ] Single
[ ] Widowed [ ] Divorced
[ ] Separated [ ] Other _____
Are you Homebound? [ ] Yes [ ] No

Migrant Worker Status [ ] Migrant [ ] Seasonal
[ ] Not a migrant or seasonal Farmworker
County of Residence _____
Living Situation [ ] Doubling Up [ ] Shelter
[ ] Street [ ] Transitional
[ ] Not Homeless [ ] Other _____
Do you Live in Public Housing? [ ] Yes [ ] No
Are You a Veteran? [ ] Yes [ ] No

Guardian's Last Name _____
First Name _____ Middle _____ Suffix___

EMERGENCY CONTACT INFORMATION

Name _____
Relationship _____
Home Phone _____
Cell Phone _____

EMPLOYMENT INFORMATION

Employer's Name _____
Employer's Phone _____
Usual Occupation _____
Usual Industry _____

GUARANTOR INFORMATION (to whom statements are sent)

Relationship to Patient _____
Last Name _____
First Name _____
Middle _____ Suffix _____
Birth Date _____
Address _____
Zip Code _____
City _____ State _____
SS Number _____
Phone Number _____
Cell Phone _____
How did you find us? [ ] Already a patient [ ] Friend
[ ] Yellow Pages [ ] Radio
[ ] Newspaper Ad [ ] Hospital
[ ] TV [ ] Web Site
[ ] Other _____

SEXUAL ORIENTATION AND GENDER IDENTITY

Sexual Orientation
[ ] Lesbian, gay, or homosexual
[ ] Straight or heterosexual
[ ] Bisexual
[ ] Something else
[ ] Don't know
[ ] Choose not to disclose

Gender Identity
[ ] Male
[ ] Female
[ ] Transgender male/female-to-male
[ ] Transgender female/male-to-female
[ ] Gender queer
[ ] Other
[ ] Choose not to disclose

MEDLINK georgia

INSURANCE and PAYMENT INFORMATION

Insurance Status Private Insurance [ ] Medicare [ ]
Medicaid [ ] Uninsured [ ]

Have you applied for Medicaid? [ ] Yes [ ] No
Medicare? [ ] Yes [ ] No
Disability? [ ] Yes [ ] No
If denied, what was the reason? _____
Number living in Household _____
Combined Income for household $_____ each [ ] Week
[ ] Month [ ] Year

Do you want to apply for fee discounts based on your household income and size? [ ] Yes [ ] No

Would you like information about or assistance with

[ ] Applying for fee Discounts [ ] Applying for Medicaid
[ ] Medicare [ ] PeachCare for Kids
[ ] the Affordable Care Act Health Insurance
[ ] Affordable Medications [ ] Other _____

Insurance Plan Name:

Policy Holder if other than the patient

Last Name _____
First Name _____
Middle _____
Address _____
City _____ State _____ Zip Code _____
Birth Date _____ Gender [ ] Male [ ] Female

Policy Information

Patient's Relationship to Policy Holder: _____
ID/Certification No.: _____
Policy/Group Number: _____

Employer Name _____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____

Policy Holder if other than the patient

Last Name _____
First Name _____
Middle _____
Address _____
City _____ State _____ Zip Code _____
Birth Date _____ Gender [ ] Male [ ] Female

Policy Information

Patient's Relationship to Policy Holder: _____
ID/Certification No.: _____
Policy/Group Number: _____

Employer Name _____

ASSIGNMENT and RELEASE:

- I hereby authorize the MedLink Georgia, Inc., to furnish information to insurance carriers concerning my illness and treatment, and direct the insurer to pay, without equivocation, directly to the MedLink Georgia, Inc., all benefits due as a result of treatment.
- I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or co-insurance. I authorize and consent for MedLink Georgia to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- A copy of this authorization will be as valid as the original.
- I consent to treatment by a Physician's Assistant or Advanced Practice Nurse acting under the supervision of a MedLink Georgia Physician.
- I consent to any services rendered to me or my dependents by the attending provider/physician(s).
- I consent to voluntary Title X Family Planning services if I request them. I understand that all Title X services are voluntary and confidential. I understand that obtaining Title X services is NOT required and is NOT a requirement to obtain other services at MedLink Georgia, Inc. I understand that I cannot be turned away for Title X services for inability to pay.
- I understand that MedLink Georgia, Inc. is not liable for any act or omission in the following of provider/physician(s) instructions.

I certify that all information given by me is true.

Signature _____ Date _____
[ ] Patient [ ] Parent [ ] Guardian