



PATIENT INFORMATION

PATIENT INFORMATION – Please Print

Last Name, First Name, Preferred Name, Middle, Suffix, Former Last name(s), Gender Reported at Birth, Birth Date, SS Number, Address, Zip Code, County of Residence, City, State, Home Phone, Cell Phone, Work Phone, e-mail, I prefer to be contacted by, Provider, Pharmacy, Imaging Center, Language, Race, Ethnicity, Marital Status, Are you Homebound?, Migrant Worker Status, Living Situation, Do you Live in Public Housing?, Are You a Veteran?

Guardian's Last Name, First Name, Middle, Suffix, Next of Kin'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, Work 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

NOTE: This data is required for federal statistical reports and is not associated with individual patients

Sexual Orientation: Lesbian, gay, or homosexual, Straight or heterosexual, Bisexual, Something else, 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

INSURANCE and PAYMENT INFORMATION

Insurance Status Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/>	Do you want to apply for fee discounts based on your household income and size? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number living in Household _____	If no, do you meet criteria for income greater than 250% of qualified income on the table available? <input type="checkbox"/> Yes <input type="checkbox"/> No
Combined Yearly Household Income, please check below: <input type="checkbox"/> \$0 -12,760.00 (100% and below) <input type="checkbox"/> \$12,761.00 – 15,949.00 (101-150%) <input type="checkbox"/> \$15,950.00 – 19,139.00 (151-200%) <input type="checkbox"/> \$19,140.00 – 25,519.00 (151-200%) <input type="checkbox"/> \$25,520.00+ (greater than 200%)	
Would you like information about or assistance with <input type="checkbox"/> Applying for fee Discounts <input type="checkbox"/> Applying for Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> PeachCare for Kids <input type="checkbox"/> the Affordable Care Act Health Insurance <input type="checkbox"/> Affordable Medications <input type="checkbox"/> Other _____	

Insurance Plan Name:

Policy Holder if other than the patient Last Name _____ First Name _____ Middle _____ Address _____ City _____ State _____ Zip Code _____ Birth Date _____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Policy Information Patient's Relationship to Policy Holder: _____ ID/Certification No.: _____ Policy/Group Number: _____ Employer Name _____
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Policy Information Patient's Relationship to Policy Holder: _____ ID/Certification No.: _____ Policy/Group Number: _____ Employer Name _____

ASSIGNMENT, RELEASE, and CONSENT

- 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 claims.
- A copy of this authorization will be as valid as the original.
- I consent to routine medical care rendered to me or my dependents by the attending provider/physician(s).
- I consent to treatment by a Physician's Assistant or Advanced Practice Nurse acting under the supervision of a MedLink Georgia Physician.
- I acknowledge that I have the right to explanations about my care and treatment in a language and manner that assures I understand my treatment options.
- I understand that I have the right to refuse treatment after risks and benefits have been explained.
- 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 some professional medical services such as laboratory and pathology services may be independent contractors and will bill me separately for their services.
- I acknowledge treatment may be rendered in an emergency without further consent.
- I understand that MedLink Georgia 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 _____
 Patient Parent Guardian

Date _____