PATIENT INFORMATION

PATIENT INFORMATION – Please Print

Last Name _____
First Name _____
Preferred Name _____
Middle _____ Suffix _____
Former Last name(s) _____
Gender Reported at Birth [ ] Male [ ] Female
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: [ ] 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 _____
Imaging Center _____
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
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___
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
[ ] Choose not to disclose
[ ] Other

INSURANCE and PAYMENT INFORMATION

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

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

HOUSEHOLD SIZE AND COMBINED YEARLY INCOME

Please circle family size then look at income range. Find where your gross household income falls and circle the amount to the right.

Family Size					
	101% or Below	102%	103%	104%	Title X (NA)
1	$13,590.00	$16,987.50	$20,385.00	$27,180.00	$33,975.00
2	$18,310.00	$22,887.50	$27,465.00	$36,620.00	$45,775.00
3	$23,030.00	$28,787.50	$34,545.00	$46,060.00	$57,575.00
4	$27,750.00	$34,687.50	$41,625.00	$55,500.00	$69,375.00
5	$32,470.00	$40,587.50	$48,705.00	$64,940.00	$81,175.00
6	$37,190.00	$46,487.50	$55,785.00	$74,380.00	$92,975.00
7	$41,910.00	$52,387.50	$62,865.00	$83,820.00	$104,775.00
8	$46,630.00	$58,287.50	$69,945.00	$93,260.00	$116,575.00

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, 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 an HIV test is included as part of standard preventative screening tests, and that I may decline having the test performed at any time.
- 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 _____ Date _____

[ ] Patient [ ] Parent [ ] Guardian