PATIENT REGISTRATION SHEET

Care Plus Family Medicine

_Chamblee _Riverdale _Duluth

PATIENT INFORMATION：

NAME: _____ _____ _____
FIRST MI LAST

ADDRESS：_____

CITY, STATE, ZIP CODE_____

HOME PHONE：_____ CELL PHONE: _____

DATE OF BIRTH：_____SSN：_____SEX: M F
MARITAL STATUS： S M D W

EMPLOYER NAME _____OCCUPATION _____
EMPLOYER ADDRESS _____

EMERGENCY CONTACT：_____
PHONE NUMBER：_____

INSURANCE CARRIER OR GUARDIAN INFORMATION (only if different from above)

NAME: _____ ___ _____DOB_____SSN _____
FIRST MI LAST
RELATIONSHIP TO THE PATIENT：_____SEX: M F

ADDRESS _____CITY_____STATE____ZIP_____

PHONE _____EMPLOYER'S NAME_____

*I give authorization to Dr. Zhang's Family Care to release medical information to:

_____ (Relationship to patient) _____

CONSENT FOR TREATMENT AND PAYMENT

I hereby authorize Dr. Zhang to provide me with medical treatment**. I understand that I am ultimately responsible for all fees for services rendered.** I hereby authorize the release of any medical necessary to file a claim with the insurance company.

Medicare/insurance: I request that payment of authorized Medicare or Insurance benefits be made either to me or on my behalf to Dr. Zhang furnished me by that physician. I authorized any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize Medicare to furnish to the above medical practice any information regarding my Medicare claims under Tile XVIII of the Social Security Act.

I hereby volunteer consent to my treatment by Dr. Zhang at his office and authorize such treatment, examinations, medications and diagnostic procedures (including but not limited to the use of radiographic and laboratory studies) as ordered by attending physicians**. I understand that payment is due at the time of service and that I am responsible for any amount not covered by insurance.** I have read this consent, am aware of its contents and fully understand that no assurance or promises have been given to me concerning the results which may be obtained by such treatment and /or procedures ordered by attending physicians.

I have read and understand the Notice of Privacy Practices.

Signature: _____ Date: _____

If minor, please write parent name_____

Pt is eligible for VFC:

____Medicaid/Peach Care ____Not Insured ____Underinsured ____American Indian/Alaska Native