TOBACCO FREE CAMPUS

PATIENT INFORMATION

DATE	SOCIAL SECURITY NUMBER	EMAIL ADDRESS		
LAST NAME	FIRST NAME		MIDDLE NAME	D.O.B.
STREET ADDRESS	CITY	STATE		ZIP
PHONE NUMBERS - HOME	CELL	MARITAL STATUS		SEX
PATIENT'S EMPLOYER	EMPLOYER PHONE #	PRIMARY CARE PHYSICIAN		
EMPLOYER ADDRESS	CITY	STATE		ZIP
PATIENT'S EMERGENCY CONTACT				
EMERGENCY CONTACT PHONE #(S)		EMERGENCY CONTACT RELATIONSHIP		

Northeast Georgia
PHYSICIANS GROUP

OCCUPATIONAL MEDICINE PATIENT REGISTRATION FORM

FRONT

505001-03413

FORM # 505001-03413 (11/30/17)

PATIENT IDENTIFICATION:

Northeast Georgia
PHYSICIANS GROUP

OCCUPATIONAL MEDICINE
PATIENT REGISTRATION FORM

BACK

Patient Name: ______________________________ DOB: ______________

Consent for Treatment:

- Permission is hereby given for any medical / surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, or Nurse Practitioner.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

Consent to Release Medical Information to the Employer:

I hereby authorize NGPG to release information related to pre-employment physical/consults to:

1) ______________ 2) ______________ 3) ______________

Tell us with whom we may discuss your protected health information:
(Name and relation-Example: Jane Doe, Wife; Jan Doe, Daughter)

1) ______________ 2) ______________ 3) ______________

- *If you do not authorize information to be released to anyone please check this statement.*

❑ **I do not authorize any information to be released to anyone other than myself.**

I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) NGPG staff can utilize to leave a message for you:

1) ______________ 2) ______________ 3) ______________

- *For Medical Records release, see form C-45.*

Acknowledgment of Receipt of Nondiscriminatory Act Notice:

☐ By initialing, I acknowledge that I received a copy of the Nondiscriminatory Act Notice.

Acknowledgement of Privacy Rights:

We may use or share your medical information with personnel involved in your care at the Health System. We may also disclose your medical information to people outside of the System, such as Health Information Exchanges. NGHS Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy.

By signing below I acknowledge that I am aware of the NGHS Notice of Privacy Practices and Individual Rights.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature: ______________________________ **Date:** ______________

Print Name: ______________________________ **Email address:** ______________