Georgia Wellness Clinic

www.georgiawellnessclinic.com
3510 Old Milton Parkway
Alpharetta, Georgia 30005
470.375.8125

Date ____ / ___ /_____

PATIENT INFORMATION

Patient Name:_____ Date of Birth ____ / ____ / ____ ☐ Male ☐ Female

Present Active Medications 1._____ 2._____ 3._____ ☐ None
Medication Allergies 1._____ 2._____ 3._____ ☐ None
Other Providers helping Patient 1._____ 2._____ 3._____ ☐ None

Pharmacy Contact: Name_____ Phone _____ Fax _____

How did you hear about us? ☐ Other Patients ☐ Insurance Co ☐ Internet ☐ Provider Referral
For Provider Referrals, Please Specify ☐ PCP ☐ Specialist
Name _____ Address _____

GUARANTOR / CUSTODIAN INFORMATION

Guarantor / Custodian Name _____ Patient Relationship: _____
Address: _____
_____

Social Security Number: _ _ _ - _ _ - _ _ _ _ Email: _____
Phone ☐ Home _____ ☐ Work _____ ☐ Cell _____
Emergency Contact: _____ ☐ Phone Address _____

CONSENT FOR DISCLOSURE under HEALTH INSURANCE AND PORTABILITY ACT (HIPAA)

Your signature below represents consent for Pediatrics and Genetics, LLC to use and / or disclose information about yourself and the patient (or another person you have authorized to sign on your behalf) that is protected under federal law, for the sole purposes of treatment, payment and health care. You also agree to have patient's medication history from the pharmacy or Rx exchange.

You understand your rights under HIPAA. You may request a copy of this document at our office or view it on our website www.georgiawellnessclinic.com.

Privacy will be protected based on the Guardian / Guarantor details in this registration form. Any exceptions to these needs to be requested in writing.

Name of Guardian / Guarantor_____ Patient Relationship_____

Signature _____ Date ___ / ___ /_____