First Care of Habersham

Please Print Date

Patient's Name_____ Date of Birth____/____/____

Last First MI Month Day Year

Address_____ City_____ State_____ Zip_____

Phone: Home____-____-____ Work____-____-____ Cell____-____-____

SS#:____-____-____ Spouse's Name (if applicable)_____

Last First MI

For Children Under 16

Parent's Name: Mother_____ SS#:____-____-____

Father_____ SS#:____-____-____

Emergency Contact_____ Relation_____

Phone____-____-____ (work/home/cell) Alternate Phone____-____-____(work/home/cell)

Health History

ALLERGIES_____

_____

_____

Symptoms: Write any symptoms you are having related to your current problem(s) or illness.

_____

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I understand that payment is due when services are rendered. I agree to abide by the policies of First Care of Habersham including the right of providers of First Care of Habersham to refer me to another physician or emergency facility if my medical problem(s) is(are) deemed too serious or complex to be safely treated at First Care of Habersham. I authorize all physicians, medical professionals, hospitals, and other medical care institutions to provide any and all necessary information regarding medical care, advice or treatment provided to me by First Care of Habersham. I certify that this information is correct to the best of my knowledge. I will not hold responsible my provider or staff of First Care of Habersham for errors or omissions that I may have made in completion of this form. I certify that I am not a recipient of Medicare, Medicaid, Peachcare, Wellcare, or Amerigroup.

Signature_____ Date_____