Tots To Teens Medical Center

303 Harris Industrial Blvd., Suite 1
Vidalia, GA 30474
(912) 537-9991

All information **MUST** be filled out in order for services to be provided. Thank you.

Patient Information

Date: _____

_____

First Name *Middle Name* *Last Name*

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Phone Number: (_____)_____ *Date of Birth*: _____ *Social Security Num*:_____

Sex: □ Male □ Female *Race*: □African American □Asian □Caucasian □Hispanic □Indian □ Native American

Insurance Type: □BCBS □Cigna □Coventry □Aetna □Other: _____

Policy #: _____

Group # (if one): _____

Guarantor Name: _____
Address: _____
City: _____ *Zip*: _____
Relation to Patient: □ Parent □ Other: _____
Social Security#: _____ DOB: _____

Mothers Name: _____

Address: _____
Street City State Zip

Social Security: _____ *Home Number*: _____

Date of Birth: _____ *Cell Number*: _____

Place of Employment: _____ Work #: _____

Email address: _____

Fathers Name: _____

Address: _____
Street City State Zip

Social Security: _____ *Home Number*: _____

Date of Birth: _____ *Cell Number*: _____

Place of Employment: _____ Work #: _____

Siblings of the patient (brothers and/or sisters): _____

Emergency Contact: _____ Phone Number: _____

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Release Form for Individuals in Care of Patient

I, _____, give Tots To Teens Medical Center permission to speak with the following people regarding my health status; including diagnosis, treatment options and plans, and payments for health services I receive from Tots To Teens Medical Center.

This consent is valid until such time as I provide Tots To Teens Medical Center written revocation of it.

Tots To Teens Medical may speak with:

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Patient Signature: _____
Date: _____

We now have the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

Patient Portal, Email and Text Message Consent for Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Tots To Teens.

Patient Name (Print):_____ DOB: _____

Parent/Guardian Name: _____

Cell Phone Number (_____)_____-_____

Carrier: ☐ AT&T ☐ Boost ☐ Cellular One ☐ Nextel ☐ Page Plus ☐ Sprint ☐ T-Mobile ☐ U.S. Cellular ☐ Virgin Mobile USA ☐ Verizon ☐ Other: _____

Email Address:

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I understand it is my responsibility to update the phone number(s) and the email address Tots To Teens has on file.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____Previous Names_____
Address_____
Birthdate _____Phone Number _____MR#_____

Provider	Name: _____ Address: _____ _____ Phone: _____ Fax: _____
Requestor	Name: **Tots To Teens Medical Center** Address: **303 Harris Industrial Blvd., Suite 1** **Vidalia, GA 30474** Phone: **(912) 537-9991** Fax: **(844) 553-6958** Delivery Preference: _X_ US Mail ___ FEDEX _X_ Fax
Information To Be Released	□Any and all records □Clinic Notes □Immunizations □Pathology Reports □X-ray/Radiology Reports □Films □EKG/ECHO Reports □Discharge Summary □History and Physical Exam □Consultation Reports □Lab Results □Operative Reports □Emergency Services □Other (please specify):_____
Reason for Release	□Continued care by another provider □Personal Use □Insurance Claim □Attorney Review □Other (please specify): _____

□ With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here:_____
□ I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
□ This authorization will automatically expire one year from the date of my signature, or _____ (period of time, for example 2 days, or 3 weeks, or 5 months) from my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Georgia.
□ I understand there may be a retrieval and copy charge associated with the release.
□ I understand that once information is released pursuant to this authorization, Tots To Teens cannot prevent the re-disclosure of the information to another third party.
□ I understand this authorization must be filled out completely,signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.
□ Except for research-related treatment, Tots To Teens will not condition treatment on my signing this authorization.

_____ _____
Signature of patient / Authorized Person Date

_____ _____
Authorized person's authority to sign Date
(Parent, guardian, power of attorney, etc.)

If you have any questions, please call the receptionist at (912) 537-9991.