Name

DOB

Date

**Garrett Medical Group, P.A.**

# PATIENT INFORMATION SHEET

MAILING ADDRESS: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE _____ IF NONE MESSAGE PHONE _____

CELL PHONE (OPTIONAL) _____ SEX _____

DATE OF BIRTH _____ MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOW

**PATIENTS** SOCIAL SECURITY NUMBER _____

**EMPLOYERS NAME:** _____

ADDRESS OF EMPLOYER: _____

CITY _____ STATE _____ ZIP CODE _____ PHONE _____

EMERGENCY CONTACT NUMBER

OUTSIDE OF HOME _____ NAME _____

**IF PATIENT IS MARRIED PLEASE FILL OUT THE FOLLOWING INFORMATION**

**SPOUSE'S** NAME: LAST _____ FIRST _____ MIDDLE _____

**SPOUSE'S** SOCIAL SECURITY NUMBER: _____ **SPOUSE'S** DOB _____

**IF THE PATIENT IS UNDER THE AGE OF 18 PLEASE FILL OUT THE FOLLOWING INFORMATION**
**(IF IN FOSTER CARE PLEASE GIVE THE FOSTER PARENTS INFORMATION)**

**FATHER'S NAME:** LAST _____ FIRST _____ MIDDLE _____

FATHER'S SOCIAL SECURITY NUMBER: _____ FATHER'S DOB _____

EMPLOYERS NAME _____ ADDRESS _____

**MOTHER'S NAME:** LAST _____ FIRST _____ MIDDLE _____

MOTHER'S SOCIAL SECURITY NUMBER: _____ MOTHER'S DOB _____

EMPLOYERS NAME _____ ADDRESS _____

**I am acknowledging the notice of Garrett Medical Group's Privacy Policies posted in the general waiting area and that a copy is available by request at the reception desk.** _____

**Signature and Date**

**PARENTAL CONSENT FOR TREATMENT**

**I give my permission for my minor child to be treated without my presence.** _____

**Signature and Date**

Name

DOB

Date

**Garrett Medical Group, P.A.**

# FINANCIAL AGREEMENT AND AUTHORIZATIONS

I authorize treatment of the person named above & agree to pay all fees and charges for myself as well as members of my family at the time treatment is rendered unless credit arrangements are agreed upon in advance. Charges shown by statement are agreed to be correct and reasonable unless protested within thirty days of the billing date. It is agreed that payments will not be delayed or withheld because coverage and all proceeds of insurance are assigned to this office where applicable. Please be aware that the responsibility of payment falls on the guarantor or person signing this document. (A copy of this assignment is as valid as the original).

Authorization to release information: I hereby authorize Garrett Medical Group, P.A. to release any and all information acquired in the course of my examination or treatment to my insurance company, including alcohol, drug and/or HIV/AIDS information. This authorization will be valid for one year and renewed at the beginning of each New Year.

_____ _____

Signature Date

# CONSENT FOR MEDICAL DISCLOSURE

By signing this authorization I give the Doctor of treatment the right to speak to (name of person or persons)_____ (relationship to patient) _____concerning my medical condition and treatment at the Garrett Medical Group. I understand that this may include the treatment of alcohol, drug and/or HIV/AIDS information. This signature will be valid for one year and renewed at the beginning of each New Year. I understand that this authorization may be revoked at anytime by notifying the provider in writing but if revoked, it will not have any effect on any actions they took before they received the revocation.

_____ _____

Signature Date

I also give, by signing this agreement, the Garrett Medical Group permission to leave a message on my answering machine for appointments, lab and/or test results, prescription refills and referral information.

_____ _____

Signature Date