GRANT PARK CLINIC
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ATLANTA GA 30315

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☸ CONFIDENTIAL PATIENT INFORMATION ~ (NOT REPORTED TO ANY AGENCIES) ☸

DATE:

______ YES ______ NO

PATIENT LAST NAME, FIRST, MIDDLE | ARE YOU A NEW PATIENT?

STREET ADDRESS | CITY | STATE | ZIP

HOME PHONE NUMBER | EMAIL ADDRESS (OPTIONAL)

SOCIAL SECURITY NUMBER | DATE OF BIRTH | SEX ______ M ______ F

BECAUSE OUR FEES ARE USUALLY ADJUSTED FOR FAMILY INCOME AND FAMILY SIZE, PLEASE COMPLETE THE FOLLOWING SECTION:

Occupation | EMPLOYER | WORK PHONE NUMBER

ANNUAL INCOME | FAMILY SIZE | MARITAL STATUS | WHAT COUNTY DO YOU LIVE IN?

PERSON TO NOTIFY IN CASE OF EMERGENCY | PHONE | RELATIONSHIP TO PATIENT

SIGNATURE (IF THE PATIENT IS A MINOR, THIS SIGNATURE CONSTITUTES MY PERMISSION FOR TREATMENT) | DATE

Our physicians, dentists, and staff are pleased to assist you with your health care needs but will *not* be available for emergencies, after hours care, or hospital care. The medical personnel who volunteer here are available *only* during the hours they are treating patients at our facility and cannot be responsible for your care during other times. Our volunteer physicians, dentists, and nurses are *not* paid for the services that they provide at Grant Park Family Health Center.

In the event of an emergency you should go to the nearest Emergency Department (Grady, Atlanta Medical, Northside, DeKalb General, Piedmont, Southern Regional, South Fulton, Crawford Long, Cobb General, Etc.). The staff at that facility should be advised that you have been treated at Grant Park Family Health Center so that we can provide them with whatever medical information we might have.

I UNDERSTAND THIS POLICY: ____ DATE ______________

If you are having tests / Labs done, and want someone other than yourself to receive these results, you must authorize that person specifically below. This authorization is valid only for records relating to your visit today.

NAME OF PERSON AUTHORIZED BY YOU | YOUR SIGNATURE | TODAY'S DATE

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