BUCKHEAD
PRIMARY CARE CLINIC

A CITY HEALTH CENTERS CLINIC

PATIENT INFORMATION

First Name: _____ **MI:** _____ **Last :** _____

DOB: _____ SSN: _____ Phone: _____

Email: _____ Address: _____

City: _____ State: _____ Zip code: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION (only fill this out if subscriber is different from patient or no card present)

Ins. Co. Name: _____ Member ID: _____

Subscriber's Name: _____ Subscriber Birthday: _____

Relationship to Patient: _____ Subscriber's SSN: _____

MEDICAL INFORMATION

Reason for visit: _____

Do you have any allergies?

☐ Yes ☐ No

If yes, please list _____

_____

_____

Are you currently taking any medications?

☐ Yes ☐ No

If yes, please list _____

_____

_____

Are you sexually active? ☐ Yes ☐ No

How many partners have you had in the last year? _____

Would you like to be checked for STD's? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

For how long? _____ How much per day? _____

Do you use recreational drugs? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

About how many drinks per week? _____

How much caffeine do you drink per day? _____

How often do you exercise? _____ per week

Have you ever been diagnosed with: ☐ Anemia ☐ Anxiety ☐ Asthma ☐ AIDS/HIV ☐ Bleeding Disorder

☐ Cancer ☐ Diabetes ☐ Depression ☐ Eating Disorder ☐ Epilepsy ☐ Gout ☐ Heart Problems ☐ ADD/ADHD

POLICY

AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by BPC, LLC.

AUTHORIZATION FOR INSURANCE BENEFITS: I authorize my insurance company to send payment directly to BPC, LLC services covered by my insurance plan.

FINANCIAL OBLIGATION: I understand that BPC, LLC will file any claims to my insurance company on my behalf and that should I fail to provide the correct information or should there be any issues that I am responsible for the cost of this visit.

AUTHORIZATION TO CONTACT ME: I authorize BPC, LLC to contact me by either phone, or mail to provide a reminder appointment, lab results, gather demographic or insurance information, or to inform me of services or events offered at the facility.

Patient / Guardian Signature: _____ **Date:** _____