# REAGAN MEDICAL CENTER

*Family Medicine, Urgent Care & Diagnostic Center*

NEW PATIENT INFORMATION

Patient's full name: _____ Sex: (M)☐ (F)☐

Address: _____

Date of birth: _____ Social Security #: _____

Marital Status: S M D W Email address: _____

Mobile phone: _____Other phone: _____

Employer: _____Occupation: _____

Emergency Contact Name: _____Phone: _____

## Insurance Information

Insured's Name: _____ Insured's DOB: _____

Insured's SSN: _____ Relationship to Patient: _____

Name of Insurance: _____ Member ID: _____

Group Number: _____ Insurance Telephone: _____

## If Minor, Parent Information

Father's name: _____ Mobile Phone: _____

Mother's name: _____ Mobile Phone: _____

I understand that I am fully responsible for this account. I request and authorization insurance company payment benefits be made to Reagan Medical Center for any services furnished to me. I also authorizes release of medical information necessary to pay the claim.

SIGNATURE: _____ DATE: _____ /_____ /_____

We will have this form ready at the office for you to sign and date, when you arrive

We utilize Physician Assistants, Nurse Practitioners and Physicians in this practice to accommodate walk-ins and appointments for same day healthcare. You may request to see a particular provider, if they are available or you may make an appointment with them. Full payment is due at the time of service unless other arrangements are made in advance. We file claims as a courtesy.

TO MAKE AN APPOINTMENT

- Call: 678-344-8700, Option 1
- Text: 678-866-1676
- Email: appointment@rmc.md
- submit online "contact us" at www.rmc.md


- *2878 Five Forks Trickum Rd, Lawrenceville, GA 30044.Tel: 678-344-8700*
- *2696 Lawrenceville-Suwanee Rd, Suwanee, GA 30024. Tel: 770-771-5570*
- *3685 Braselton Hwy, Dacula, GA 30019. Tel: 678-546-9800*
- *289 Grayson Highway, Lawrenceville, GA 30046. Tel: 770-771-5560*
- *10160 Medlock Bridge Rd, Johns Creek, GA 30097. Tel: 678-387-1600*
- *Diagnostic Center: Lawrenceville, GA 30044. Tel: 678-221-8000*

*Fax (all locations) 678-344-8600* *www.rmc.md*

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## HIPPA AUTHORIZATION FORM

Patient Name: _____ Date: _____

Date of birth: _____ Sex: ☐ (M) ☐ (F)

I give my permission for you to leave medical / lab information for me via the following sources:

Mobile phone: _____

Email: _____

Other phone: _____

I authorize the following individuals to have full access to my health information:

_____ _____

Name Relationship

_____ _____

Name Relationship

### Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have received a copy of Reagan Medical Center Notice of Private Practices.

Signature: _____ Date: _____

Patient or Guardian

We will have this form ready at the office for you to sign and date, when you arrive


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