Primary Care of Southwest Georgia – Patient Information

❑ **Check here if you need help filling out this application.**

Last Name	First Name	Middle Initial	Maiden or Previous Name

Mailing Address	City	State	County	Zip Code

Contact Number:
Home ____________________ Cell____________________ Alternate ________________ Leave Message? _______

Preferred number for us to call: ❑ Cell ❑ Home ❑ Work

Also notify using: ❑ Email ❑ Text Message ❑ Patient Portal
Email Address: ____

Preferred time to call: ❑ Morning ❑Afternoon ❑ Evening

Pharmacy:

Social Security Number	Marital Status	Sex ❑ F ❑ M	Date of Birth: Month _____ Day _____ Year _______

Emergency Contact Information

Name ________________________________
Relationship to Patient____________________
Address__________________________________
City, State, Zip __________________________
Phone Number(s) ___________________________
Alternate Contact:___________________________

Residence Situation

❑ Permanent
❑ Public Housing
❑ Foster Care (Peds)
❑ Homeless
❑ Temporary with Family or Others/Doubled Up
❑ Salvation Army
❑ Rescue Mission
❑ Transitional Housing or Program
❑ Streets

Have you ever been in the military? ❑ Yes ❑ No
Are you a Veteran ❑ Yes ❑ No
Are you a Migrant ❑ Yes ❑ No
Seasonal Farm Worker? ❑ Yes ❑ No

Advance Directive
I have an Advance Directive ❑ Yes ❑ No
If no, would you like more information about Advance Directives? ❑ Yes ❑ No
❑ Living Will ❑ Durable Power of Attorney for Health Care

Race: ❑ Black/African American ❑ White ❑ Multiple Race ❑ Asian ❑ Native Hawaiian ❑ Pacific Islander
❑ American Indian/Alaska Native **Hispanic Ethnicity:** ❑ Yes ❑ No ❑ Prefer Not to Disclose Race/Ethnicity

Preferred Language: ______________________ **Do you need an interpreter?** ❑ Yes ❑ No

Currently Employed: ❑ Yes ❑ No **Name & Number of Employer**

Primary Care Provider:

Is Patient Covered by Insurance? ❑ Yes ❑ No If yes Check all that Apply ***If yes, please give current card(s) to the receptionist.**

❑ Medicare	❑ Medicaid	❑ Commercial	❑ Workers Comp	❑ PCSG's Discount Program	❑ Other __________
❑Part A Only	❑ Well Care	❑ Blue Cross			
❑Parts A & B	❑ Peach State	❑ CIGNA			
	❑ Amerigroup	❑ ___________			
	❑ Planning 4hb				

Contracted Lab ❑ Quest Diagnostic ❑ Archbold ❑ Lab Corp. ❑ Solstas ❑ Unknown ❑ Other __________________
*Please note it is the patient's responsibility to verify the lab your insurance company will cover. Without this information you will be responsible for any unpaid lab fees.

Has the Patient Applied for Medicaid/Medicare Coverage?
❑ Yes ❑ No
Would you like more information on applying for coverage and other services? ❑ Yes ❑ No
Do you have access to regular Dental Care ❑ Yes ❑ No

Barriers
Do you have a
❑ Speech Impediment **and/or**
❑ Hearing Impaired?

Financial Statistics
For Data Reports (Not Specific to Patient)
Household Income: _________
How many people living in home: ______

Name of Other Person Responsible for Bill

Relation to Patient ❑ Parent ❑ Guardian ❑ Other ____________
You must provide proof of guardianship/Power of Attorney if not the legal parent.

Address	Contact Number

The foregoing information is true to the best of my knowledge and I request PCSG to provide me and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by PCSG. I acknowledge by signing below that I have received a copy of and read the PCSG HIPAA Privacy Policy Notice along with PCSG's Patient's Rights & Responsibilities.

Patient or Guardian Signature X____________________________________ **Date** ____________________________

Form Number:101.32A
Date Revised: 11/08/2018

Primary Care of Southwest Georgia, Inc.

In an effort to better serve all the patients in our communities we ask you to answer the following questions:

Patient Additional Information **DATE OF BIRTH:**

LAST NAME: **FIRST NAME:** **MIDDLE INITIAL:**

LANGUAGE PREFERENCE:

□ English □ Spanish □ Other Translator Required: □ Yes

RACE:

□ White or Caucasian □ Black or African American □ American Indian or Alaska Native

□ Native Hawaiian or other Pacific Islander □ Other Race

WHO IS YOUR PRIMARY CARE GIVER?

□ Self □ Parent □ Grandparent □ Sibling □ Spouse □ Life Partner □ Caregiver

□ Ward of Court/Guardian □ Unknown

SEXUAL ORIENTATION - WHAT DO YOU THINK OF YOURSELF AS:

Sexual Orientation is defined as to which gender(s) a person is physicaly attracted: to the opposite gender (heterosexual), to the same gender (homosexual), or to both genders (bisexual).

□ Lesbian, Gay or Homosexual □ Straight or Heterosexual □ Bisexual

□ Something else, please describe ____________________

□ Don't know □ Decline to answer, please explain why____________________

GENDER IDENTITY - WHAT IS YOUR CURRENT GENDER IDENTITY? (Check all that apply)

Gender Identity is defined as a person's identification as male or female, which may or may not correspond to the person's body or their sex at birth (meaning what sex was originally listed on a person's birth certificate).

□ Male □ Female □ Female-to-Male (FTM)/Transgender Male/Trans Man

□ Male-to-Female (MTF)/Transgender Female/Trans Woman □ Genderqueer, neither exclusively male nor female

□ Additional Gender Category/(or Other), please specify____________________

□ Decline to Answer, please explain why____________________

SEX AT BIRTH - WHAT SEX YOU WERE ASSIGNED AT BIRTH ON YOUR ORIGINAL BIRTH CERTIFICATE

□ Male □ Female □ Decline to Answer, please explain why____________________

PLEASE INDICATE YOUR PREFERRED PROVIDER:

____

Signature of Patient/Representative: ____________________ **Date:** ____________________

Relationship if other than Patient: ____________________

Form Number: 101.32B
Revised Date: 08/08/17