



e-mail address: _____

DATE	NAME (Last)	First	MI
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Sex:	DATE OF BIRTH	AGE	MARITAL STATUS			
____ Male			SINGLE	MARRIED	DIVORCED	WIDOWED
____ Female			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Street	Apt #	City	State	Zip
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Permanent Street (if Different)	City	State	Zip
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Social Security #	Home Phone	Cell Phone	Work Phone
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Employer/School	Street Address	City	State	Zip
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Referred By: Ask A Nurse Yellow Pages Maller Magazine Newspaper Radio
 Physician Insurance Employer Employee Employer Other.

Person responsible for bills	Relationship	Date of Birth
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Street	Apt #	City	State	Zip
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Social Security #	Home Phone	Cell Phone	Work Phone
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Employer	Street Address	City	State	Zip
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Person to Contact in an Emergency	Relationship
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Home Phone	Cell Phone	Work Phone
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I consent to the examination, treatment and procedures which may be performed during this visit, including emergency treatment deemed necessary by North Georgia Urgent Care staff. I understand that the examination I am about to receive should not be considered to be in lieu of my ongoing and preventative health care needs, which should be provided by my personal physician. I also authorize the release of information requested by my insurance company and the release of my medical records (current and historical) to health care providers with whom I or my treatment physician(s) may consult for medical treatment.

Signature of Patient &/or Legal Guardian or Parent	Date
_____	_____