Muhammad Abbasi, M.D.
Charles Holloway, PA-C
1775 Access Road #C
Covington, GA 30014
770.255.0123

Thank you for choosing Alliance Family Care for your medical needs. Included below is material that we will need to prepare for your New Patient Visit. Please fill these forms out in print and return them to the front desk receptionist with your ID and insurance card(s). If you are currently taking medications, please provide a list of dosages to the nurse and medical provider.

Our practice offers a patient portal, a way for you to communicate with us 24 hours a day, seven days a week. It is our way of making it more convenient for you to get in touch with us from scheduling appointments to requesting prescriptions, all online at our Patient Portal. With the email that you provide us, you should receive a confirmation email that will outline the directions to set this option up for you.

Please arrive at least 30 minutes prior to your new patient appointment. We look forward to making your visit the very best possible.

Sincerely,
Staff at Alliance Family Care

REGISTRATION INFORMATION

First Name:________________________ Middle In: ____

Last Name: __________________________________

Date of Birth: _______________ Gender: M __ F __ O __

Social Security Number ____________________________

Email: ____

Home Address: __________________________________

____

City ST ZIP

Home Phone: _______________________

Cell Phone: _______________________

Work Phone: _______________________ ext: ________

Marital Status: ___Single __Married __ Partner __ Divorced __Widowed

Employment: __ Full Time __Part Time __Active Military Duty __Retired

Employer Name: ____

Pharmacy Name/Location: ____

Pharmacy Phone: ____

REGISTRATION INFORMATION

In case of an emergency, who should be notified?

First Name: ________________________________

Last Name: _________________________________

Relation: __________________________________

Phone Number: ____________________________

Other Demographics

RACE: ___ **American Indian or Alaskan Native**
___ **Asian**
___ **Native Hawaiian or other Pacific Islander**
___ **Black or African American**
___ **White**
___ **Hispanic**
___ **Other Race**

Are you Hispanic or Latino? _____Yes ____No

ADVANCE DIRECTIVE: Do you have

__ **Do Not resuscitate**

___ **Living Will**

___ **Power of Attorney**

___ **Surrogate Decision Maker Not Provided (have none of the above)**

MEDICAL INSURANCE INFORMATION

Do you currently have medical insurance ____Yes __ No

If yes, what is name of primary medical insurance?

____

ID number____

Group Number ____

Subscriber Name ____

Subscriber Date of birth: __________________________________

Do you have secondary medical insurance ? ____Yes ___ No

If yes, what is name of primary medical insurance?

____

ID number____

Group Number ____

Subscriber Name ____

Subscriber Date of birth: __________________________________

INSURANCE INFORMATION

I, the undersigned, herby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services, rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned and personally signed the particular claim.

I, ________________________ hereby authorize _________________________to pay and hereby assign
(Name of Insured) (Name of Insurance Company)

directly to ____ all benefits, if any, otherwise payable to me
(Provider Name)
for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____________________________ will be credited to my account, in accordance with the above said
(Provider Name)
agreement.

____________________________________ ___________________
Authorized Signature of Subscriber Date

Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES (Federal HIPPA Policy)

I acknowledge that I was given the opportunity to review and/or read a copy of the Notice of Privacy Practices (HIPPA Policy) and understood the notice.

______________________ **___________________________**
Patient Name (Print) **Parent or Authorized Agent**

____
Patient Signature