MMG MiltonMedicalGroup
735 N. Main St. – Suite 1100, Alpharetta GA 30009 Ph: 678.827.9157 Fax: 470.299.6262

PATIENT INFORMATION

Patient Name:	(last)	(first)	(middle)	
Address:	(street)	(city)	(state)	(zip)
Date of Birth:		SSN:	Sex: M/F	Phone:
Race:		Marital Status:	Email:	
Patient's Employer:			Occupation:	
Spouse or Parent Name:			Employer:	
Pharmacy Name:			Phone:	
Pharmacy Address:				

Insurance Information – This section must be completed to file insurance				
Person Insured (check one)	Self ☐	Spouse ☐	Parent ☐	Other ☐
Insured Person's Name			Relationship:	
Date of Birth (MM/DD/YYYY):		SSN:	Phone:	

Insurance Coverage

Primary Ins		Secondary Ins	
Policy Holder		Policy Holder	
ID Number		ID Number	
Group Number		Group Number	

Emergency Contact:

Name:		Relationship:		
Phone:		Do you have a living will?	Yes ☐	No ☐

Payment Responsibility:

All professional services rendered are charged to the patient. We will file insurance claims for the patient if the patient is covered by an insurance plan with which our office has a negotiated contract. If the patient is not covered by an insurance plan that our office has a negotiated contract with, it is the responsibility of the patient to pay for services when rendered, regardless of insurance coverage.

Insurance Authorizations: Release of Information/Electronic Prescribing

I authorize the release of any medical or other information necessary to process my insurance claims for my child, or myself. I authorize release of information to other providers of service needed for continuation of my medical care, such as specialists, hospitals etc. I request that payment of authorized benefits is made on my behalf to Milton Medical Group, LLC for any services furnished me by that party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for my treatment. I authorize provider to electronically prescribe medication directly to my pharmacy.

Date:		Signature:	
Patient or Legally Authorized Representative			

Consent to obtain external prescription history

I authorize Milton Medical Group and its providers to obtain and view my prescription history via all prescription services. This includes other unaffiliated medical providers, insurance companies, and pharmacy benefit managers and it may include prescriptions back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan. I certify that I read and understand the scope of my consent and that I authorize the access. Patient Initials:

Notice of Privacy Practices (HIPAA): Signature:	
Date:	