TRIAGE FORM

TO BE COMPLETED BY PATIENT:

DATE:__________________ TIME:__________

NAME:_____________________________________ DOB:________________________

PHARMACY:____

REASON FOR BEING SEEN:____

WHEN DID SYMPTOMS START:____

ALLERGIES:____

MEDICATION CHANGES SINCE LAST VISIT:____

NEW DOCTORS SEEN SINCE LAST VISIT:______________________________________

NEW MEDICAL PROBLEM SINCE LAST VISIT:__________________________________

INTIAL EACH LINE BELOW:

_____ All information provided is true and accurate

_____I acknowledge that insurance will be filed but it is not a substitute for payment. Some companies allow for fixed amounts covered, and others pay a percentage. It is my responsibility to pay any deductible amount, co-payment or co-insurance, or any balance not covered by insurance.

____In the case that I do not have insurance, or my insurance is denied or only partially pays, I am fully responsible for the unpaid balance.

____Family Care Dahlonega may be out of network with some insurances, and regardless of my insurance, double coverage or out of network status, I am responsible for any amounts due to Family Care Dahlonega after processing an insurance claim. This is in reference to all insurances but not limited to any HMO, PPO, Medicare, or Advantage plan.

SIGNATURE BELOW ACKNOWLEDGES ABOVE AND THAT YOU HAVE RECEIVED HIPAA AND PRIVACY PRACTICES:

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SIGNATURE OF PATIENT/RESPONSIBLE PARTY

STAFF TO FILL OUT:

BP	PULSE	O2	RR	TEMP	HEIGHT	WEIGHT