Greenville Family Medicine
Community Partners for Healthcare Excellence

NEW PATIENT APPLICATION

INSTRUCTIONS:	Please ensure the application is completed in its entirety. Incomplete applications will not be accepted. If you're completing applications for multiple individuals, please submit a separate form for each person. Completed applications can be returned to the office in person or by mail (1000 Red Ball Trail Greenville, IL 62246), by fax (618-690-2189) or by email (office@greenvillefamilymedicine.com).
PATIENT INFORMATION:	Name _____ Date of Birth _____ Address _____ City, State, Zip _____ Phone _____ Email _____
FAMILY INFORMATION: *Please list family members who are **current** GFM patients.*	Name _____ Relation _____ Name _____ Relation _____ Name _____ Relation _____ Name _____ Relation _____
INSURANCE INFORMATION:	Insurance Name _____ Policy/Member #: _____ Group # _____ ☐ Check this box if you do not currently have insurance.
CARE TEAM INFORMATION:	Current Primary Care Provider: _____ Current Specialists: _____
PRESCRIPTIONS / MEDICATIONS: *This office does not encourage narcotic use in most situations.*	Name _____ Dosage _____ Frequency _____ Name _____ Dosage _____ Frequency _____ Name _____ Dosage _____ Frequency _____ Name _____ Dosage _____ Frequency _____ Name _____ Dosage _____ Frequency _____
MEDICAL / SURGICAL HISTORY: *Please list all conditions for which you will be seeking treatment.*	Medical history: _____ _____ _____ Surgical history: _____ _____
PREFERRED PROVIDER:	☒ Dr. Whitney Leininger
FOR OFFICE USE ONLY:	Date Received _____ Application Status ☐ Approved ☐ Denied Date Patient Informed _____

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AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION:	Name _____ Date of Birth _____ Address _____ City, State, Zip _____ Phone _____ Email _____
RECORDS FROM: *Who has the information you want released?*	Name _____ Address _____ City, State, Zip _____ Phone _____ Fax _____
RELEASE TO: *Where do you want the information sent?*	Name Greenville Family Medicine Address 1000 Red Ball Trail City, State, Zip Greenville, IL 62246 Phone 618-664-1240 Fax 618-690-2189
INFORMATION TO BE RELEASED:	Dates of service: All available dates of service ☒ All records ☒ Progress/visit notes ☒ Consultation reports ☒ Operative notes ☒ Lab results ☒ Radiology reports ☐ Billing records
RELEASE INSTRUCTIONS:	☒ Fax to: 618-690-2189 ***OR*** ☒ Email to: office@greenvillefamilymedicine.com
RELEASE PURPOSE:	☒ Transferring care to Greenville Family Medicine

- ✓ This authorization will expire in 12 months from the date signed unless otherwise specified: _____.
- ✓ I may revoke this authorization at any time by notifying Greenville Family Medicine (GFM) in writing. The revocation will not affect any actions the practice may have taken prior to the receipt of the written revocation.
- ✓ I am aware that if the receiver re-discloses my information, it may no longer be protected by federal privacy laws. GFM is not liable for any consequences of such re-disclosure.
- ✓ GFM is not responsible for any charges incurred for the reproduction of medical records by another health care provider or entity because of this request. Any charges are to be directed to the patient's Responsible Party.
- ✓ The information in my health record may include information regarding mental health, development disability, alcohol or drug abuse, child abuse and neglect, sexual assault, adult disabilities, and infectious diseases, including HIV. Refusal to consent to release information will result in such confidential records not being released. If you do not want such information to be released, state the information to be excluded: _____.

Your signature indicates that you have read and understand this form, and you authorize the release of your information as described above.

_____ _____
Patient or legal representative signature Date

_____ _____
Name of legal representative Relationship to patient