3301 N. Oak St. Ext.
Valdosta, Ga 31605
Phone:229-242-6061 * Fax:229-242.6151

Adult New Patient Approval Form

Date: ______________________________ Date of Birth: ____________________ SS# ________________________

First Name: ________________________ Middle Name: ___________________ Last Name: ____________________

Address ____

(City, St, zip) ____ County ______________________________ SEX: M/F

Home Number: ________________________ Cell Number: _____________________ E-mail: ___________________

Reason for coming: ____

Insurance Information:

Primary: _________________________ ID # __________________________ Group# __________________

Previous Physicians:

1. ____
2. ____

Have you seen Dr. Griner previously as your Primary Care Physician? □ yes □ no

If so, when ________________________

Please list any family members who are current or previous patients of Dr. Griner.

1. ______________________________ 3. ___________________________
2. ______________________________ 4. ___________________________

Current / Previous Diagnosis:

1. ______________________________ 3. ___________________________
2. ______________________________ 4. ___________________________

Current/ Previous Medications:

1. ______________________________ 3. ___________________________
2. ______________________________ 4. ___________________________

Signature of Authorizing Party: ____ Date: _____________

Print Name: ____

Relationship to Patient: ____

Witness Signature: ____ Date: ______________

********* If accepted, medical records MUST be received before any appointments can be made*********

Disclaimer:
Griner Medical Group provides quality healthcare for all ages. We are a multidisciplinary practice that is comprised of physicians and staff that are professional, courteous, and detail-oriented. We do not treat chronic pain with narcotic pain medications. Referrals in these types of cases will be sent for chronic pain management.

In Office Only Dr. Griner:

Accepted _________ Declined _____________