|  |  |
| --- | --- |
| **FAX SENT DATE:** |  |

Provider Information:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLINIC NAME: CLINIC ZIP CODE:** | | | | | |  | | | **CLINIC ZIP CODE** | | | |
|  | | | | | |  | | |  | | | |
| **HEALTH CARE PROVIDER:** | | | | | |  | | |  | | | |
|  | | | | | | | | | | | | |
| **CONTACT NAME:** | | | | | |  | | |  | | | |
|  | | | | | | | | | | | | |
| **FAX NUMBER:** | |  | **PHONE NUMBER:** | | | | | | | | | |
|  | | |  | | | |  | | | | | |
|  | | | | |  | | | |  | | | |
| **I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)** | **YES** | | |  | **NO** | | |  | | **DON’T KNOW** |  |  |

Patient Information:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT NAME** | | | | | | | **DATE OF BIRTH** | | | | | | **GENDER** | | | | | | | | | | |
|  | | | | | | |  | | | | | |  | | MALE | | |  | | FEMALE | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **ADDRESS** | | | | | | | **CITY** | | | | | | | | ZIP CODE | | | | | | | | |
|  | | | | | | |  | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **PRIMARY PHONE NUMBER HM WK CELL CELL SECONDARY PHONE NUMBER** | **H WK CELL** |  | W | C | |  | | **SECONDARY PHONE NUMBER** | | | | | | H | | | W | | | | C | |
|  |  |  |  |  |  |  |  | | | | | | |  | |  |  | |  | |  |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **LANGUAGE PREFERENCE (***PLEASE CHECK ONE***)** | | | | | ENGLISH | | | |  | SPANISH |  | OTHER | | | |  | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | I am ready to quit tobacco and request the Georgia Tobacco Quit Line contact me to help me with my quit plan. | | | | | | | | | | | | | | | | | | | |
| *(Initial)* | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | I DO NOT give my permission to the Georgia Tobacco Quit Line to leave a message when contacting me. | | | | | | | | | | | | | | | | | | | |
| *(Initial)* | | *\*\* By not initialing, you are giving your permission for the quitline to leave a message.* | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| PATIENT SIGNATURE: | | | |  | | | | | | | | | | | | | DATE: | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| The **Georgia Tobacco Quit Line** will call you. Please check the BEST 3-hour time frame for them to reach you. ***NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.*** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  |  | | **6AM – 9AM** | |  |  | **9AM – 12PM** |  |  | **12PM – 3PM** | | |  |  | **3PM – 6PM** | | | |  | **6PM – 9PM** |
|  | | | | | | | | | | | | | | | | | | | | | |
| **WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT** (*CHECK ONE*): | | | | | | | | | | |  | **Primary #** | | | |  | | **Secondary #** | | | |