PEACHWOOD MEDICAL GROUP

DATE: ______________________

PCP: ______________________ ACCOUNT: ______________________

PATIENT REGISTRATION FORM

*** PATIENT**				
NAME		SSN		DOB
ADDRESS		SEX	PHONE	
CITY	ST	ZIP	CELL	
MARITAL STATUS	EMPLOYER/SCHOOL			EMP PHONE

*** RESPONSIBLE FOR PATIENT (ONLY IF PATIENT IS UNDER 18 YRS OLD) (Only one name please)**				
NAME		SSN		DOB
ADDRESS		SEX	PHONE	
CITY	ST	ZIP	MARTIAL STATUS	
RELATION TO PATIENT		EMPLOYEER		

*** INSURANCE INFORMATION**	
NAME OF INSURANCE	ID#
GROUP#	EFFECTIVE DATE

*** SUBSCRIBER / POLICY HOLDER (WHO IS THE EMPLOYEE?)**	
NAME	DATE OF BIRTH
SS#	RELATION TO PATIENT

*** EMERGENCY CONTACT / GUARDIAN (That lives outside the household)**			
NAME			PHONE
ADDRESS			RELATION TO PATIENT
CITY	ST	ZIP	GUARDIAN NAME

This office will bill all HMO and PPO contracted payer - copayments and/or deductibles must be paid at time of visit.

I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to the physicians or suppliers of services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible within a 30-day period for all charges whether or not paid by said insurance. I hereby authorize said insurance to release information necessary to secure payment.

Signed: ______________________ Date: ______________________