

South Forsyth Family Medicine and Pediatrics Patient Registration Form

PATIENT INFORMATION: (ALL INFORMATION ON THIS FORM MUST BE COMPLETED)

Patient: (Last, First MI) _____
 Address: _____ Date of Birth: _____
 City, State, Zip: _____ Home Phone: _____
 Single Married Divorced Separated Widowed Other Cell Phone: _____
 Male/Female: ___ Race: _____ Hispanic/Non-Hispanic: _____ Language: _____
 SS#: _____ School: _____
 Employer: _____ Work Phone: _____
 Emergency Contact: _____ Phone: _____ Relationship: _____

PARENT INFORMATION: (COMPLETE IF UNDER AGE OF 18 ONLY)

Father's Name: _____	Mother's Name: _____
SS#: _____	SS#: _____
Address: (Check if Same as Pt _____)	Address: (Check if Same as Pt _____)
_____	_____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
_____	_____

INSURANCE INFORMATION: (ALL INFORMATION ON THIS FORM MUST BE COMPLETED)

Primary Insurance: _____	Who Holds Policy? _____
ID#: _____	Group#: _____
DOB: _____	SS#: _____
Secondary Insurance: _____	Who Holds Policy? _____
ID#: _____	Group#: _____
DOB: _____	SS#: _____

I voluntarily give consent for my medical treatment or my child's medical treatment to the Providers at South Forsyth Family Medicine and Pediatrics. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

 Signature Date

I consent to have messages regarding tests results and appointment reminder left on the following:

Home Voice mail Cellular Voice mail Work Voice mail

Who can we thank for referring you to our practice?

___ Friend: _____ ___ Insurance ___ : Website ___ Phonebook ___ Other

