Northeast Georgia
PHYSICIANS GROUP

PATIENT REGISTRATION FORM

Date:	Reason for Visit:

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY #	SEX ❑ Male ❑ Female	I IDENTIFY MYSELF AS: ❑ Male ❑ Female ❑ Other: _____	BIRTH DATE (mm/dd/yyyy)	

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	MOBILE PHONE	E-MAIL ADDRESS

MARITAL STATUS	INTERPRETER NEEDED?	PREFERRED LANGUAGE	RACE	ETHNICITY
❑ M ❑ S ❑ D ❑ W	❑ Yes ❑ No		❑ Black ❑ White ❑ Asian ❑ Other	❑ Hispanic ❑ Non-Hispanic

RELIGION	COMMUNICATION PREFERENCE	PRIMARY CARE PHYSICIAN
	❑ Mail ❑ Phone ❑ Email ❑ Patient Portal	

EMPLOYER INFORMATION

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE

BUSINESS ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	MOBILE PHONE

GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

GUARANTOR'S NAME	RELATIONSHIP	SOCIAL SECURITY #

ADDRESS (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH	SEX

EMPLOYER	HOME PHONE	WORK PHONE	MOBILE PHONE

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	NAME OF ADULT PRESENTING MINOR FOR TREATMENT	RELATIONSHIP

INSURANCE INFORMATION

	INSURANCE COMPANY (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	SUBSCRIBER ID	GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER
	SECONDARY INSURANCE (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	SUBSCRIBER ID	GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER

INJURY/ACCIDENT INFORMATION (IF APPLICABLE)

❑ Auto/MVC ❑ Worker's Comp ❑ Other Accident:

DATE	TIME	PLACE	NATURE

Who may we thank for referring you to our office?

How did you hear about our office?

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE.