Patient Registration Form

1. Patient Information (Please complete all spaces)

Patient Last Name	First Name	Date of Birth	Age	Patient Gender ❒ M ❒ F

Street Address	City	State	Zip Code	Social Security Number

Home Telephone ❒ check box if primary	Work Telephone ❒ check box if primary	Cell Telephone ❒ check box if primary	Email Address

Need Interpreter? ❒ Yes ❒ No	Primary Language	Marital Status	Written Language	Ethnicity Hispanic or Latino? ❒ Yes ❒ No	Race	Religion

Activate MyChart ❒ Yes ❒ No	Employer Name	Employment Status ❒ Full-time ❒ Unemployed ❒ Disabled ❒ Part-time ❒ Retired ❒ Student

Employer Address	City	State	Zip Code	Employer Telephone

Emergency Contact Last Name	First Name	Pharmacy Telephone Number

Emergency Contact Relation to Patient	Legal guardian? ❒ Yes ❒ No	Hearing Impaired? ❒ Yes ❒ No	Visually Impaired? ❒ Yes ❒ No	Home Telephone ❒ check if primary	Work Telephone ❒ check if primary	Cell Telephone ❒ check if primary

Primary Care Physician

2. Responsible Party / Guarantor ❒ (Check if self and skip this section)

Guarantor Last Name	First Name	Guarantor Street Address	City	State	Zip Code

Guarantor Relation to Patient	Guarantor Gender ❒ M ❒ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone

Guarantor Employer	Employment Status ❒ Full-time ❒ Unemployed ❒ Disabled ❒ Part-time ❒ Retired ❒ Student	Employer Telephone

3. Medical Insurance Policy Holder ❒ (Check if self and skip this section)

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name

Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name

Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize WellStar Medical Group to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

Signature of Patient / Legal Guardian:	**Date:**