Northwest GA Medical Clinic, P.C. 1105 N. 5th Ave., Rome, GA 30165

PATIENT REGISTRATION

NAME (LAST / FIRST / MIDDLE)			DATE OF BIRTH
MAILING ADDRESS		CITY STATE, ZIP	
PHONE (HOME)	(WORK)	EMPLOYER	
S. S. #	DRIVER'S LICENSE #	REFERRING DR. OR PRIMARY CARE DR.	
SPOUSE'S NAME	DATE OF BIRTH	EMPLOYER	PHONE
IF UNDER 18 PARENT / GUARDIAN		MARITAL STATUS S M W D SEP	
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE	ADDRESS	RELATION

INSURANCE INFORMATION

1) INSURANCE COMPANY	I.D. / POLICY NUMBER		GROUP #
EMPLOYEE'S NAME	EMPLOYEE'S SSN #		RELATIONSHIP TO PATIENT
EMPLOYER	EMPLOYEE'S DATE OF BIRTH	EMPLOYEE'S ADDRESS	
CLAIMS ADDRESS			
2) INSURANCE COMPANY	I.D. / POLICY NUMBER		GROUP #
EMPLOYEE'S NAME	EMPLOYEE'S SSN #		RELATIONSHIP TO PATIENT
EMPLOYER	EMPLOYEE'S DATE OF BIRTH	EMPLOYEE'S ADDRESS	
CLAIMS ADDRESS			
MEDICARE #	MEDICAID I.D. #		

RESPONSIBLE PARTY (OTHER THAN INSURANCE)

BILLING NAME	RELATIONSHIP
BILLING ADDRESS	PHONE #

METHOD OF PAYMENT FOR TODAY'S SERVICES: ❒ CASH ❒ CHECK ❒ CREDIT CARD

ASSIGNMENT AND RELEASE OF INFORMATION

1. I hereby authorize payment of medical benefits directly to Northwest Georgia Medical Clinic.
2. I authorize Northwest Georgia Medical Clinic to release my medical records or any other information necessary for my medical care or for processing medical insurance claims.
3. I certify that the information provided by me for payment of services is correct.
4. Due to this clinic's strict policy of releasing information only to the patient or legal guardian, we need your authorization, as follows, to discuss your medical care, appointments, or financial information with anyone else:
5. I HAVE RECEIVED A COPY OF THE PRIVACY NOTICE.

I authorize Northwest Georgia Medical Clinic to furnish any medical or financial information to my personal representative, ______________________, at ________________ (phone number).

In the event Northwest Georgia Medical Clinic is unable to reach me, a clinic representative may leave a message on my answering machine. ❒ Yes ❒ No

Patient's Name ______________________ (Please Print) Date ________________

Patient or Legal Guardian's Signature ______________________

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