Patient Registration Form

Name: (last)_____ (first) _____ (middle) _____ (preferred) _____

DOB: _____ Age: _____ Gender: _____

Social Security #: _____-_____-_____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____-_____Cell phone: (_____)_____-_____ Work phone: (_____)_____-_____

Which contact number do you prefer to be reached at? Home / Cell / Work

Marital Status: _____ Spouse's Name: _____

Employer: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Phone number: _____ Relationship: _____

Complete if under 18 years of age or a student

Father's Name: _____ Contact number: _____ Employer: _____

Mother's Name: _____ Contact number: _____ Employer: _____

Guarantor (name to whom statements are sent)

Name: (last)_____ (first)_____ DOB: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present your insurance card(s) and driver's license to the patient service representative

Primary Insurance Name: _____ Insured Name: _____

Relationship: _____ DOB: _____ Social Security #: _____-___-_____ Employer:_____

Secondary Insurance Name: _____ Insured Name: _____

Relationship: _____ DOB: _____ Social Security #: _____-___-_____ Employer:_____

Consent to Treat

I agree the above information is true and accurate to the best of my knowledge. I hereby authorize Jennie Stuart Medical Group and all subsidiaries affiliated with Jennie Stuart Medical Group, to provide medical services, tests, procedures, interventions, drugs, supplies, and other care that the provider in his / her professional judgement decides are necessary for my health and well-being. My authorization extends to employees and clinicians of Jennie Stuart Medical Group and all subsidiaries.

Patient / Responsible Party Signature: _____ Date: _____