SOUTHERN OB-GYN ASSOCIATES, P.C.

220 Northside Drive • Valdosta, GA 31602 • 229-241-2800

Preferred Contact Method
(Circle One)
Phone / Mail / E-mail

PATIENT REGISTRATION FORM

Date _____

By whom were you referred? Name: Address:

Patient Name_____
LAST FIRST MIDDLE

Street Address:_____

City:_____ State_____ Zip Code_____

Home Telephone ( )_____Work Phone ( ) _____Cell Phone ( )_____

Social Security #_____ E-mail Address _____

Date of Birth_____ Age_____ Race_____ Ethnicity_____

Preferred Language: ☐ English ☐ Other_____ Religion_____

Marital Status_____ Years Married_____ Number of Children_____

Occupation_____ Highest Education_____

Place of Employment_____ How Long Employed?_____

Employer Address (Street)_____ (City)_____

(State)_____ (Zip)_____ Phone ( )_____ Ext_____

Spouse/Guardian Name_____ D.O.B._____ Cell Phone ( )_____

Spouse/Guardian Place of Employment_____ Spouse/Guardian Social Security #_____

Employer Address (Street)_____ (City)_____

(State)_____ (Zip)_____ Work Phone ( )_____ Ext_____

Primary Insurance Co._____ Policy/Group #_____

Name of Policyholder_____ Policyholder D.O.B._____ Policyholder SSN _____-_____-_____

Policyholder Place of Employment_____ Effective Date _____

Secondary Insurance Co._____ Policy/Group #_____

Name of Policyholder_____ Policyholder D.O.B._____ Policyholder SSN _____-_____-_____

Person Responsible for Payment, If Not Above_____

Address_____ Phone ( )_____

Person to Notify in Case of Emergency, Other Than Spouse/Guardian_____

Relationship_____ Phone ( )_____

Additional Emergency Contact_____ Phone ( )_____

Relationship_____

Drug Allergies, If Any_____

I consent to treatment necessary for the care of the above named patient. Furthermore, I certify that the information furnished above is accurate, and I agree to notify the practice if any of the furnished information should change during the course of treatment. I understand that the patient may refuse treatment to the extent permitted by law. Also, it is understood that when refusal of treatment by the patient, or legally authorized representative, prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated by the provider upon reasonable notice.

I authorize the release of all medical records to the referring and family physicians, to my insurance company, and to myself if applicable. I allow fax transmittal of my records, if necessary. This authorization is subject to revocation at any time. Without prior revocation, this authorization will automatically expire 5 years from the date of this form.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. If I am insured by a plan in which the physicians are preferred providers, I am responsible for paying any deductible or copay amount that may apply for my visit. Additionally, I understand that a rebilling fee will be applied to those accounts that are 30 days or more past due and that Southern OB-GYN Associates, P.C. reserves the right to take appropriate collection action of seriously delinquent accounts. I acknowledge understanding of the financial policies of the practice and agree to uphold my financial obligations as described.

_____
Patient Signature / Guardian if patient is a minor

Revised 9/2011

OFFICIAL USE ONLY

Appt Type Provider Chart #