

SOUTHERN OB-GYN ASSOCIATES, P.C.
220 Northside Drive • Valdosta, GA 31602 • 229-241-2800

PATIENT REGISTRATION FORM

Date _____

[Please Check Assigned Provider This Visit]

PHYSICIANS

___ Thomas H. Moseley, Jr., M.D.
___ Bolan P. Woodward, M.D.
___ Roy E. Swindle, M.D.
___ Alex M. Culbreth, III, M.D.

___ Joe C. Clifton, M.D.
___ Pamela H. Temples, M.D.
___ Nicole D. Yarbrough, D.O.

NURSE MIDWIVES

___ Marie Dazey, C.N.M.
___ Debbie Crews, C.N.M.
___ Vickie Hankla, C.N.M.
___ Teresa Johnson, C.N.M.
___ Stacy Reid, C.N.M.

NURSE PRACTITIONERS

___ Paula L. Bennett, R.N.C.
___ Gina S. Dungan, N.P.C.

By whom were you referred? Name: _____ Address: _____

Patient Name _____

LAST

FIRST

MIDDLE

Street Address: _____

City: _____ State _____ Zip Code _____

Home Telephone () _____ Social Security # _____

Cell Phone () _____ E-mail Address _____

Date of Birth _____ Age _____ Race _____ 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 _____ Age _____

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

Employer Address (Street) _____ (City) _____

(State) _____ (Zip) _____ Phone () _____ Ext _____

Primary Insurance Co. _____ Policy/Group # _____

Name of Policyholder _____ Policyholder D.O.B. _____ Effective Date _____

Policyholder Place of Employment _____ Policyholder Social Security # _____

Secondary Insurance Co. _____ Policy/Group # _____

Person Responsible for Payment, If Not Above _____

Address _____ Phone () _____

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

Address _____ Phone () _____

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