Appt Type: ______________
Provider: ______________
Ref. By: ________________

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

Chart # ______________

PATIENT REGISTRATION FORM

Preferred Contact Method: □ Phone □ Mail □ Email

Patient: Last Name ________________________________ First __________________________ Middle ______________

Date of Birth ___________ **Age** ______ Social Security # ______ - _____- _______ Race __________ Ethnicity __________

Address: Street ____ **City** ______________ State ______ Zip Code _________

Email Address: ____

Telephone: Home (_____) ______ - ________ Cell (_____) ______-_________ Work (_____) ______-________ Ext _______

Preferred Language: □ English □ Other ______________ Religion ____________________ **Highest Education** _________

Marital Status: □ Single □ Married □ Divorced □ Widowed Years Married _______ Number of children ________

Occupation ___________________ Place of Employment: ______________________________ How Long Employed ______

Employer Address _______________________________________ City _______________ State _____ Zip Code __________

□Spouse □Parent □Guardian

Name _____________________________________D.O.B.________ SSN ______- ____-________ Cell (_____) _____-______

Employer ____ Work (_____) ________-_________ Ext __________

Employer Address ____ City ________________ State _____ Zip Code ________

Insurance:

Primary Insurance _____________________________ Policy # ____________________ Group # __________________

Policyholder: Name ____ D.O.B. ____________ SSN: _____-_____-________

Employer ____ Effective Date ________________

Secondary Insurance _____________________________ Policy # ____________________ Group # ________________

Policyholder: Name ____ D.O.B. ____________ SSN: ______-_____-________

Employer ____ Effective Date __________________

Person Responsible For Payment, If Not Above

Name ___________________________ Address ______________________________________ Phone (_____) _____-_______

Additional Emergency Contacts Other Than Listed Above

Name ____ Relationship _________________ Phone (_____) _____-_______

Name ____ Relationship _________________ Phone (_____) _____-_______

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 OBGYN 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 / Parent or Guardian if patient is a minor Date