The Heart Center of Northeast Georgia Medical Center

PATIENT REGISTRATION FORM

DATE:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	
MAILING ADDRESS	CITY	STATE	ZIP
STREET ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	E-MAIL ADDRESS	
BIRTH DATE	SEX	MARITAL STATUS	RACE
ETHNICITY	LANGUAGE	SOCIAL SECURITY #	
PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE	
BUSINESS ADDRESS	CITY	STATE	ZIP

SPOUSE INFORMATION

SPOUSE'S NAME	DATE OF BIRTH	SEX	SOCIAL SECURITY #
EMPLOYER	ADDRESS	WORK PHONE	

INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE (IF ANY)	SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
EMPLOYER	ADDRESS	WORK PHONE		

PARENT INFORMATION IF PATIENT IS UNDER 18 YEARS OLD

GUARANTOR'S NAME	RELATIONSHIP	SOCIAL SECURITY #
ADDRESS (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH	SEX
EMPLOYER	PRIMARY PHONE #	
EMPLOYER'S ADDRESS		
NAME OF ADULT PRESENTING MINOR FOR TREATMENT	RELATIONSHIP	

EMERGENCY CONTACT (A RELATIVE OR FRIEND)

NAME	RELATIONSHIP	PRIMARY PHONE #
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE.

PLEASE SIGN CONSENT ON BACK. >>>>>

The Heart Center of Northeast Georgia Medical Center

Annual Consent / Authorizations

Patient Name: ______________________________ DOB: ______________

Consent for Treatment:

- Permission is hereby given for any medical / surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, Nurse Practitioner, or Nurse Midwife.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by a Physician Assistant.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to The Heart Center, LLC, and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

Consent to Obtain Medical Records:

I hereby authorize The Heart Center, to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

Consent to Release Medical Information & / or Records to a Spouse, Family Member or Significant Other:

I hereby authorize The Heart Center (THC), to release any information contained in my medical record to the person or persons listed:

1) ____________________ 2) ____________________ 3) ____________________

- *If you do not authorize information to be released to anyone please check this statement.*
  ❑ **I do not authorize any information to be released to anyone other than myself.**

I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) staff can utilize to leave a message for you:

1) ____________________ 2) ____________________ 3) ____________________

Patient Satisfaction:

Our office utilizes an outside company to assist us in obtaining feedback regarding patient satisfaction that we utilize for our quality assurance program. If you do not wish to participate in this survey process, please notify the registrar.

Acknowledgement of Privacy Rights:

By signing below I acknowledge that I am aware of the THC notice of Privacy Practices and Individual Rights.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature: ______________________________ **Date:** ____________________