☐ **Marietta Office**
☐ **Towne Lake Office**

OB-GYN ASSOCIATES

Patient Registration Form

DATE ____/____/____

Physician (Please check one)

☐ Dr. Kelley ☐ Dr. Huffman ☐ Dr. Windom ☐ Dr. Chappell ☐ Dr. Tackitt ☐ Dr. Killian ☐ _____

When calling for today's appointment: ☐ Were you assigned one of the doctors by our receptionist, or ☐ Did you choose the doctor you wished to see

PATIENT INFORMATION

Patient Name (First, MI, Last)	Last 4 digits of Soc. Sec. # XXX - XX -	Date of Birth / /	Marital Status
Address		Apt # - Lot # - Bldg. # - C/O	
City	State	Zip Code	Primary Phone #: Home Cell ( ) -
Email Address	May we contact you by email? ☐ Yes ☐ No		Alternate Phone #: Home Cell ( ) -
Race	Circle One: Hispanic / Latino Non Hispanic / Latino		Who referred you to this practice?

***Disclaimer:** We are asking for your race and ethnicity because some people have higher risks of developing certain diseases such as high blood pressure, diabetes, and heart disease.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with quality health care. We greatly appreciate your participation.

PATIENT EMPLOYMENT INFORMATION

Employment Status: _____ Employed _____ Unemployed _____ Retired _____ Student		Circle One: Full Time Part Time
Employer Name:	Employer Phone #:	Occupation:

INSURANCE INFORMATION

Name of **PRIMARY** Insurance Company	ID #		Group #
Name of Policy Holder:	Relationship to Patient	Last 4 digits of SS # XXX - XX -	Policy Holder's DOB
Policy Holder's Employer:	Work #: ( ) -		Co-pay Amount:
Name of **SECONDARY** Insurance Company	ID #		Group #
Name of Policy Holder:	Relationship to Patient	Last 4 digits of SS # XXX - XX -	Policy Holder's DOB
Policy Holder's Employer:	Work #: ( ) -		Co-pay Amount:

EMERGENCY INFORMATION

Emergency Contact Name:	Relationship to Patient :	Circle One: Home Cell Work ( ) -

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible or co-insurance amount, and that I am financially responsible for all charges whether or not paid by said insurance. Finally, I will be responsible for any charges incurred due to non-notification of required insurance information necessary to process my health insurance claims.

SIGNATURE DATE

POS Reorder # 1610595