

Promise Pediatrics
375 Boynton Drive
Ringgold, GA 30736

PATIENT REGISTRATION FORM

Date: _____

Acct #: _____

PERSON RESPONSIBLE FOR PAYING THE BILL

Billing Name:			SS#:
Street Address:			
City:	State:	Zip:	Phone#:
Relationship to Patient:			DOB:
Employer Name:			
Street Address:			
City:	State:	Zip:	Phone#:

PATIENT INFORMATION

Patient Name:			Acct #
Street Address:			
City:	State:	Zip:	Phone#:
DOB:	SS#:	Sex:	
Employer Name:	Employer Phone#:	Marital Status:	
Street Address:			
City:	State:	Zip:	

EMERGENCY INFORMATION (Outside Home)

Emergency Contact Name:			
Street Address:			
City:	State:	Zip:	Phone#:
Employer:			
Street Address:			
City:	State:	Zip:	Phone#:
Relationship to Patient:			

TYPE OF VISIT

Personal Workers Comp MVA / Auto Accident Other Accident Sports Injury

REFERRAL SOURCE

Who referred you to this office?

Friend/Relative Doctor Yellow Pages Media Ad Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Name:	Phone#:
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PRIMARY INSURANCE

PRIMARY INSURANCE	PRIMARY SUBSCRIBER (Policy Holder)
Ins Co. Name:	Relationship to Patient:
Address	Name:
City, State & Zip:	Address
Phone:	City, State & Zip:
Effective Date:	Phone:
Group #:	DOB: Sex:
Policy #:	SSN#:
Pri Care Prov.:	Employer Name:
Comments:	Address
	City, State & Zip:
	Phone:

SECONDARY INSURANCE

SECONDARY INSURANCE	SECONDARY SUBSCRIBER (Policy Holder)
Ins Co. Name:	Relationship to Patient:
Address	Name:
City, State & Zip:	Address
Phone:	City, State & Zip:
Effective Date:	Phone:
Group #:	DOB: Sex:
Policy #:	SSN#:
Pri Care Prov.:	Employer Name:
Comments:	Address
	City, State & Zip:
	Phone:

I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize the release of any medical information necessary to process insurance claims and certify that the information contained herein is correct.

Medicare patients: I authorize payment of Medigap benefits by the Medigap insurer as listed be made on my behalf to the provider or group, for services rendered.

Except under certain circumstances (Workers' Compensation; governmental programs such as Medicare or TN Care; and physician participating health insurance plans), I will be responsible for the full payment amount of the charges.

Signature of Patient/Responsible Person

Date