West Georgia Cardiology

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REGISTRATION FORM

Section I: Patient Information

Date_____

Physician Name: _____

Name: _____ I prefer to be called: _____

Address: _____City:_____State:_____Zip:_____

Phone (_____) _____¬_ Work Phone (_____) _____ Cell Phone (_____) _____

The best time to contact me is: _____ A.M. P.M. on my Home phone Work phone Cell

Email Address_____

Date of Birth: _____¬_____ Social Security Number: _____

Will you require an interpreter? ☐ Yes ☐ No Native Language: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Pharmacy Name and Number:_____

Whom may we thank for referring you?

_____

SECTION II—(If not Primary Insured)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone:
(____)_____

Employer_____ Work Phone (____) _____

SSN#_____

PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID.
PAYMENT IS EXPECTED AND APPRECIATED AT TIME OF SERVICES.