EMORY HEALTHCARE

THE EMORY CLINIC, INC.

**PLEASE PRINT OR TYPE**

# PRE-REGISTRATION INFORMATION

**For Office Use Only:**

| |
|---|
| Medical Record Number: |
| Appointment Date/Time: |
| Emory Clinic Physician: |

**Have you ever been treated at the Emory Clinic, Emory Univ. Hospital, Crawford Long or Egleston? _____**

## PATIENT INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PATIENT NAME | LAST | FIRST | MIDDLE | SOCIAL SECURITY NUMBER | DATE OF BIRTH | | SEX |
| MAIDEN NAME | LAST | FIRST | MIDDLE | EMPLOYER | | MARITAL STATUS | |
| STREET | | APT | | OCCUPATION | | | |
| CITY | STATE | ZIP | | STREET | | CITY | |
| HOME PHONE: ( ) | BUSINESS/DAYTIME PHONE: ( ) | EXT | | CELL PHONE: ( ) | STATE | ZIP | |
| E-MAIL ADDRESS | | | | | | | |

## PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION):

| | | | | | | |
|---|---|---|---|---|---|---|
| LAST | FIRST | MIDDLE | RELATIONSHIP | SOCIAL SECURITY NO. | | D.O.B. |
| STREET | APT | | EMPLOYER | OCCUPATION | | |
| CITY | STATE | ZIP | STREET | | | |
| HOME PHONE: ( ) | BUSINESS/DATIME PHONE: ( ) | | CITY | STATE | ZIP | |

## EMERGENCY CONTACT - IF RESIDING AT A DIFFERENT ADDRESS (e.g., Friend or Relative):

| | | | |
|---|---|---|---|
| LAST | FIRST | MIDDLE | RELATIONSHIP |
| STREET | APT | | HOME PHONE: ( ) |
| CITY | STATE | ZIP | BUSINESS/DAYTIME PHONE: ( ) |

## REFERRING PHYSICIAN

| | | | | |
|---|---|---|---|---|
| LAST | FIRST | MIDDLE | PHONE: ( ) | |
| STREET | CITY | STATE | ZIP | |

## PRIMARY CARE PHYSICIAN

| | | | | |
|---|---|---|---|---|
| LAST | FIRST | MIDDLE | PHONE: ( ) | |
| STREET | CITY | STATE | ZIP | |

**PLEASE COMPLETE REVERSE SIDE**

**- OVER -**

# FINANCIAL INFORMATION

**PLEASE BRING INSURANCE CARDS, REFERRAL FORMS (HMOs, POSs, PPOs), OR AUTHORIZATION TO BILL WORKMAN'S COMPENSATION OR OTHER THIRD PARTY PAYOR.**

## PRIMARY INSURANCE:

| | | | | | |
|---|---|---|---|---|---|
| PRIMARY INSURANCE CARRIER NAME | | | POLICY# | GROUP# | COPAY / PLAN TYPE (HMO/PPO) |
| ADDRESS TO MAIL CLAIMS | | | SUBSCRIBER'S NAME/DATE OF BIRTH | | VERIF. OF BENEFITS PHONE |
| CITY | STATE | ZIP | SUBSCRIBER'S SOCIAL SECURITY NUMBER | | PRECERTIFICATION PHONE |
| BEGINNING DATE: | REFERRAL NO. (IF APPLICABLE) | | PRECERTIFICATION NUMBER (IF APPLICABLE) | | PRIMARY CARE PHYSICIAN |

## SECONDARY INSURANCE:

| | | | | | |
|---|---|---|---|---|---|
| PRIMARY INSURANCE CARRIER NAME | | | POLICY# | GROUP# | COPAY / PLAN TYPE (HMO/PPO) |
| ADDRESS TO MAIL CLAIMS | | | SUBSCRIBER'S NAME/DATE OF BIRTH | | VERIF. OF BENEFITS PHONE |
| CITY | STATE | ZIP | SUBSCRIBER'S SOCIAL SECURITY NUMBER | | PRECERTIFICATION PHONE |
| BEGINNING DATE | REFERRAL NO. (IF APPLICABLE) | | PRECERTIFICATION NUMBER (IF APPLICABLE) | | PRIMARY CARE PHYSICIAN |

**IS THIS VISIT DUE TO A WORK RELATED CONDITION? _____**
**WILL YOU BE USING WORKER'S COMPENSATION INSURANCE? _____**

| | | | | | | |
|---|---|---|---|---|---|---|
| EMPLOYER | | | WORK COMP INSURANCE COMPANY NAME | | | ADJUSTOR NAME |
| STREET | | | STREET | | | DATE/DESCRIPTION OF INJURY |
| CITY | STATE | ZIP | CITY | STATE | ZIP | W/C POLICY NO. |
| PHONE TO VERIFY W/C ( ) | | | W/C INSURANCE PHONE ( ) | | | CLAIM NO. |



**1. FINANCIAL AGREEMENT**
I hereby assume full responsibility for all charges incurred for professional services rendered by Emory Clinic physicians, unless the services are deemed "paid in full" as a result of a contractual agreement between The Emory Clinic and my insurer.

**2. AUTHORIZATION FOR RELEASE OF INFORMATION**
I hereby authorize The Emory Clinic to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

**3. GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS**
I authorize my health insurance benefit plan to pay directly to The Emory Clinic, the surgical and/or medical benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to the Clinic for charges not covered by this agreement.

**4. MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST**
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**Signature:** _____ **Date:** _____