EMORY CLINIC

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 University Hospital, Emory University Hospital Midtown or Egleston? **YES** **NO**

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: ( )		CELL PHONE: ( )	STATE	ZIP
EMAIL ADDRESS:						

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

LAST	FIRST	MIDDLE	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH
STREET		APT	EMPLOYER	OCCUPATION	
CITY	STATE	ZIP	STREET		
HOME PHONE ( )	BUSINESS/DAYTIME 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

FINANCIAL INFORMATION

PLEASE BRING INSURANCE CARD(S), 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 NO.		PRECERTIFICATION PHONE ( )	
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE		PRECERTIFICATION NO. (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

SECONDARY INSURANCE:

SECONDARY 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 NO.		PRECERTIFICATION PHONE ( )	
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE		PRECERTIFICATION NO. (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

IS THIS VISIT DUE TO A WORK-RELATED CONDITION? YES NO
WILL YOU BE USING WORKER'S COMPENSATION INSURANCE? YES NO

EMPLOYER			WORK COMP INSURANCE CO 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 The 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 Emory 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**: _____