PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

PATIENT INFORMATION:

NAME: _____ GENDER: ❑ Male ❑ Female

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____ E-MAIL: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS:

_____

Street / P.O. Box / Apt. No. City / State / Zip Code

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

DOMESTIC INFORMATION:

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

SPOUSE/OTHER NAME: _____ DATE OF BIRTH: _____

EMPLOYER: _____CELL PHONE: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____

Street / P.O. Box / Suite # City / State / Zip Code

PREFERRED LANGUAGE: ***Must complete.*** ❑ English ❑ Spanish ❑ Other: _____

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian

❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards in order to file your insurance claims.

PRIMARY INSURANCE: _____ INS ID#:_____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

SECONDARY INSURANCE: _____ INS ID#:_____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

IF SERVICES ARE BEING PROVIDED TO YOUR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

MOTHER/GUARDIAN: _____ DOB: _____ SS#: _____

ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

FATHER/GUARDIAN: _____ DOB: _____ SS#: _____

ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

I hereby authorize Galen Medical Group, its physicians and staff, to render appropriate medical care to my dependent listed under the patient information section on the front of this form.

_____ _____
Signature of Responsible Party ***Date***

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, my physician's plans for health care, etc.

Signature: _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED

ADVANCED DIRECTIVES:

It is the right of every adult citizen in Tennessee and Georgia (18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an Individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial, Workers' Compensation, Liability, and/or any other insurance benefits be made on my behalf to Galen Medical Group for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____ _____
Signature of Patient ***Date*** ***Signature of Responsible Party/Insured***

THANK YOU