

PLEASE PRINT OR TYPE

MAIL PROMPTLY



# Northeast Georgia Medical Center

## OB Pre-Registration Form

PATIENTS SHOULD COMPLETE THIS FORM NO MORE THAN 4 MONTHS PRIOR TO THEIR EXPECTED DATE OF DELIVERY.

Form should be mailed or faxed to the OB Registration office, fax (770) 219-7329 or if you have any questions please call (770) 219-1483.

### PATIENT'S INFORMATION

PATIENT'S OB GROUP (CHECK ONE PLEASE)		<input type="checkbox"/> LAKESIDE OBGYN		EXPECTED DATE OF DELIVERY		
<input type="checkbox"/> HEALTH DEPT. / CLINIC		<input type="checkbox"/> LANIER OBGYN				
<input type="checkbox"/> HERITAGE OBGYN		<input type="checkbox"/> LONGSTREET OBGYN				
PATIENT NAME (LAST, FIRST, MIDDLE)			MARITAL STATUS	BIRTHDATE	SOCIAL SECURITY #	
STREET ADDRESS		CITY	STATE	ZIP	COUNTY	PHONE
EMPLOYER NAME AND PHONE NUMBER					PRIMARY CARE PHYSICIAN	

### SPOUSE OR NEAREST RELATIVE INFORMATION

NAME (LAST, FIRST, MIDDLE)			BIRTHDATE		SOCIAL SECURITY #	
STREET ADDRESS		CITY	STATE	ZIP	COUNTY	PHONE
EMPLOYER NAME AND PHONE NUMBER					RELATIONSHIP TO PATIENT	

### INSURANCE INFORMATION


(IF AVAILABLE, PLEASE PROVIDE A COPY OF THE CURRENT INSURANCE CARD, BOTH FRONT AND BACK. WITHOUT PROOF OF CURRENT INSURANCE, YOUR ACCOUNT WILL BE CONSIDERED A SELF-PAY ACCOUNT AND YOU WILL BE RESPONSIBLE FOR ALL CHARGES.)

PRIMARY INSURANCE CARRIER		CONTRACT NUMBER (MEMBER ID)		GROUP NUMBER	POLICY HOLDER'S NAME
INSURANCE PHONE NUMBER	EMPLOYER				EMPLOYER'S PHONE NUMBER
SECONDARY INSURANCE CARRIER		CONTRACT NUMBER (MEMBER ID)		GROUP NUMBER	POLICY HOLDER'S NAME
INSURANCE PHONE NUMBER	EMPLOYER				EMPLOYER'S PHONE NUMBER
PATIENT'S MEDICARE NUMBER			PATIENT'S MEDICAID NUMBER		
PRECERT NUMBER					

### AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted for the hospital/physician to release any medical information that may be necessary for the completion of my hospital claims.

Signed \_\_\_\_\_ Date \_\_\_\_\_

no two are the same 

Northeast Georgia Medical Center

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