



WellStar Physicians Group Patient Registration Form

1. Patient Information (Please include all information as shown on insurance card.)

Patient's Last Name		Patient's First Name		Date of Birth
Street Address			Patient's Gender	
Street Address 2			SSN	
City	State	Zip Code	Patient's Primary Language	
Home Telephone		Alternate Telephone		
Emergency Contact Name		Emergency Contact Telephone		
Physician to be Seen		E-mail Address		
Primary Care Physician		Referred By		

2. Medical Insurance Policy Holder (Check if self and complete only **Insurance Information.**)

Primary Insurance Company	Policy Number	Group Number	
Insurance Telephone	Policy Holder Last Name	Policy Holder First Name	
Relationship to Patient	Policy Holder SSN	Policy Holder Date of Birth	
Street Address		Employer Name	
Street Address 2		Work Telephone	
City	State	Zip Code	Home Telephone
Secondary Insurance Company	Policy Number	Group Number	
Last Name	First Name	Date of Birth	
Insurance Telephone	SSN	Relationship to Patient	

3. Responsible Party/Guarantor (Check if self and complete only **Employment Information.**)

Last Name		First Name		Date of Birth
Street Address			SSN	
Street Address 2			Relationship to Patient	
City	State	Zip Code	Home Telephone	
Employer Name		Work Telephone		

Complete only if patient is a minor and information differs from above.

Parent's Last Name		Parent's First Name		
Street Address		City	State	Zip Code

4. Assignment of Benefits/Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize this office to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians.

Signature of Patient/Legal Guardian:	Date:
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