Cardiovascular & Thoracic Surgeons
Gwinnett Medical Group
Patient Registration Form

PATIENT REGISTRATION			
NAME(Last,First,Middle)	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If applicable)		
CITY,STATE,ZIP	CITY,STATE,ZIP		
HOME PHONE	CELL PHONE		
MAY WE CONTACT YOU THROUGH EMAIL ❑ Y ❑N	EMAIL ADDRESS		
PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)		
ADDRESS	ADDRESS		
CITY,STATE,ZIP	CITY,STATE,ZIP		
WORK PHONE	WORK PHONE		

RESPONSIBLE PARTY INFORMATION (If different than above)			
NAME (Last,First,Middle)	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS(If applicable)		
CITY,STATE,ZIP	CITY,STATE,ZIP		
RELATIONSHIP TO PATIENT			

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY		POLICY #
NAME OF INSURED	**DATE OF BIRTH**	GROUP #
ADDRESS OF INSURANCE		COPAY AMOUNT
CITY,STATE,ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

SECONDARY INSURANCE (If applicable)		
NAME OF INSURANCE COMPANY		POLICY #
NAME OF INSURED	**DATE OF BIRTH**	GROUP #
ADDRESS OF INSURANCE		COPAY AMOUNT
CITY,STATE,ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

PLEASE TURN FORM OVER AND COMPLETE THE REMAINING INFORMATION ON THE BACK. PLEASE SIGN ON THE FRONT AND THE BACK	
SIGNATURE OF PATIENT/GUARDIAN	DATE

Marital Status: Single____ Married____ Widowed____ Legally Separated____Divorced____

Student Status: Not a Student____ Full-time Student____ Part-time Student____

EMERGENCY CONTACT	
NAME	RELATIONSHIP
HOME PHONE NUMBER	DAYTIME PHONE NUMBER
GUARANTOR EMPLOYMENT INFORMATION	
EMPLOYER NAME	
WORK PHONE NUMBER	EXTENSION
INSURANCE INFORMATION	
PRIMARY INSURED EMPLOYER (If different from patient employer)	
SECONDARY INSURED EMPLOYER (If applicable)	

Medicare Part B Beneficiaries:

Do you have Medicare Part B due to: Age_____ Disability_____ End-Stage Renal Disease_____
Are you employed? No_____ Yes_____ *Number of employees_____
Do you have employer group health plan coverage? No_____ Yes_____
Is your spouse employed? No_____ Yes_____ *Number of employees_____
Are you covered trough your spouse's insurance? No_____ Yes_____
*If twenty (20) or more employees, then Medicare is secondary payer. If disabled and under age 65, if one hundred (100) or more employees, Medicare is secondary.

SOCIAL/SPIRITUAL/CULTURAL:
Occupation: ________________________❑ Retired ❑ Other: ______________________________
Learning Preferences**:** ❑ Verbal/Listening ☒ Written/Reading ☒ Demonstration ☒ No preference
Communication needs or religious/spiritual/cultural beliefs that will affect your care? ❑ Y ❑ N
Explain: ____
Do you have any body piercing jewelry? ❑ Y ☒ N Location: ____________________________________
Sleep Problems: ❑ **None** ❑Excessive daytime sleepiness ☒ Loud snoring ☒Long pauses during sleep
Do you feel safe returning home? ❑ Y ❑N Explain: ______________________________________
Do you feel that you have been abused, neglected, or exploited by someone close you? ❑Y ❑ N
Explain:
____
Religious Preference:
____

Primary Care Physician

WHO MAY WE THANK FOR YOUR REFERRAL?

Referred By	Ins. Directory	Friend
Yellow Pages	Direct Mail	Website
Physician	Other	

Please be prepared to pay for office visits at the time of your appointment. Our office accepts cash, check or credit card.

SIGNATURE OF PATIENT/GUARDIAN **DATE**