809 Cleveland Ave S.W.
Atlanta, GA 30315
404-767-2536 / Voice
www.cwhallc.com

# New Patient Registration Form

**Name:** _____ **Patient ID#:** _____ ☐**Male** ☐ **Female**
**Address:** _____ **Date of Birth:** _____/_____/_____ **Age:** _____
_____ **Social Security #:** _____-_____-_____

**City, State, Zip:** _____ ☐ **Single** ☐ **Married** ☐ **Divorced /Separated**
**Home Phone:** ( ) - **Work:** ( ) - **Cell:** ( ) -
**E-Mail Address:**

## PATIENT EMPLOYMENT

☐ Employed ☐ Retired

☐ Unemployed ☐ Other (Student/Minor)

Employer: _____

Phone: ( ) -

## EMERGENCY CONTACTS

Name:_____

Phone: ( ) - Relationship: _____

Name: _____

Phone: ( ) - Relationship: _____

## GUARANTOR

☐ Same as patient

Name: _____

Address: _____

_____

City, State, Zip: _____

## EMPLOYMENT

Employer: _____

Employer Phone: ( ) -

Guarantor Phone: ( ) -

Guarantor SSN#: _____-_____-_____

Guarantor Date of Birth: _____/_____/_____

## PRIMARY INSURANCE

☐ Same as Patient ☐ Same as Guarantor

☐ Other

Insured: _____

Insured: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____-_____-_____

Insured's ID #: _____

Policy Group #: _____

Insured's Date of Birth: _____/_____/_____

## SECONDARY INSURANCE

☐ Same as Patient ☐ Same as Guarantor

☐ Other

Insured: _____

Insured: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____-_____-_____

Insured's ID #: _____

Policy Group #: _____

Insured's Date of Birth: _____/_____/_____


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# CURRENT INSURANCE CARD REQUIRED

**PLEASE NOTE:** Our office **MUST** have a copy of your current insurance card or you will be expected to pay in full full at the time of service. Enrollment forms will not be accepted. We will not be able to call for insurance verification at the time of your visit.

## Guarantee of Payment for Services & Assignment of Benefits

It is the policy of this office that you must pay for services at the time they are rendered except in the case of surgeries. If you are a surgical patient, we will file your claim for you and you will be responsible for that portion of the bill that is not covered by your insurance. Prior to leaving the office today please be sure to get any questions you may have about this policy answered.

By signing this form you are accepting personal responsibility for payment of all charges in the event that the insurers or guarantor listed on the prior page fail to make prompt payment. In the event that we are forced to place this account with an attorney for collection, you agree to pay all customary and reasonable attorney's fees incured by this office in the collection of our fees.

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I hereby authorize my insurance benefits to be paid directly to my physician and I accept personal responsibility for any non-covered charges. I further authorize my physician to release any information required in order to process this claim and receive payment.

I hereby attest that I have read this document in its entirety and fully understand the information contained herein including but not limited to the guarantee of payment and assignment of benefits as outlined above.

**Signature:** _____ **Date:** _____/_____/_____

**Name Printed:** _____

**Relationship to Patient:** _____
(If the signatory is not the patient – e.g. parent or guardian)

**Witness:** _____ **Date:** _____/_____/_____

**Witness Name:** _____ **Title:** _____