



DOCTORS HOSPITAL

Attn: Patient Access
 616 19th Street
 Columbus, GA 31902
 Phone: (706) 494-4262
 Fax: (706) 494-4148

PRE-REGISTRATION INFORMATION

DATE OF TREATMENT	TYPE OF TREATMENT (I.E. LAB, SURGERY, X-RAYS, INPATIENT)	PHYSICIAN'S NAME
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PATIENT INFORMATION (PLEASE PRINT CLEARLY)

PATIENT'S LEGAL NAME (LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PATIENT'S HOME ADDRESS (STREET)			(CITY / STATE)	(ZIP)	HOME PHONE NO. W/ AREA CODE
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGAL SEP <input type="checkbox"/> UNKNOWN	PRIMARY LANGUAGE		RELIGIOUS PREFERENCE	STUDENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	
PATIENT'S EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY		PATIENT'S EMPLOYER PHONE NO. W/ AREA CODE		OCCUPATION	
EMPLOYER'S NAME & ADDRESS (STREET)			(CITY / STATE)	(ZIP)	

RESPONSIBLE PARTY (IF UNDER AGE 18, LIST PARENT INFORMATION)

RESPONSIBLE PARTY'S NAME (LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATION TO PATIENT
RESPONSIBLE PARTY'S HOME ADDRESS (STREET)			(CITY / STATE)	(ZIP)	HOME PHONE NO. W/ AREA CODE
RESPONSIBLE PARTY'S EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY		RESPONSIBLE PARTY'S EMPLOYER PHONE NO. W/ AREA CODE		OCCUPATION	
EMPLOYER'S NAME & ADDRESS (STREET)			(CITY / STATE)	(ZIP)	

OTHER RESPONSIBLE PARTY (PARENT CARRYING SECONDARY COVERAGE OR SPOUSE IF SPOUSE IS INSURED)

OTHER RESPONSIBLE PARTY'S NAME (LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATION TO PATIENT
OTHER RESPONSIBLE PARTY'S HOME ADDRESS (STREET)			(CITY / STATE)	(ZIP)	HOME PHONE NO. W/ AREA CODE
OTHER RESPONSIBLE PARTY'S EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY		OTHER RESPONSIBLE PARTY'S EMPLOYER PHONE NO. W/ AREA CODE		OCCUPATION	
EMPLOYER'S NAME & ADDRESS (STREET)			(CITY / STATE)	(ZIP)	

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE			NAME OF SECONDARY INSURANCE		
NAME OF INSURED PERSON		RELATIONSHIP TO PATIENT	NAME OF INSURED PERSON		RELATIONSHIP TO PATIENT
INSURED PERSON'S EMPLOYER		INSURED'S DATE OF BIRTH	INSURED PERSON'S EMPLOYER		INSURED'S DATE OF BIRTH
POLICY, CERTIFICATE OR ID NUMBER		GROUP NUMBER	POLICY, CERTIFICATE OR ID NUMBER		GROUP NUMBER
INSURANCE ADDRESS, CITY / STATE, ZIP			INSURANCE ADDRESS, CITY / STATE, ZIP		
PHONE NO. W/ AREA CODE		EFFECTIVE DATE OF COVERAGE	PHONE NO. W/ AREA CODE		EFFECTIVE DATE OF COVERAGE



PRE-REGISTRATION INFORMATION
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MEDICARE (IF APPLICABLE)

MEDICARE NUMBER	PART A <input type="checkbox"/> YES <input type="checkbox"/> NO	PART A EFFECTIVE DATE	PART B <input type="checkbox"/> YES <input type="checkbox"/> NO	PART B EFFECTIVE DATE
HAS THE PATIENT BEEN HOSPITALIZED OVERNIGHT IF YES, WHICH HOSPITAL? IN THE LAST 60 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
PATIENT'S RETIREMENT DATE	SPOUSE'S RETIREMENT DATE	ARE YOU CURRENTLY RECEIVING HOSPICE OR HOME HEALTH SERVICES?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF COMPANY

EMERGENCY NOTIFICATION AND NEXT OF KIN INFORMATION

NAME	RELATION TO PATIENT	HOME PHONE NO. W/ AREA CODE
ADDRESS (STREET)	(CITY / STATE)	(ZIP)
		WORK PHONE NO. W/ AREA CODE

MISCELLANEOUS INFORMATION

We are required by the State of Georgia to obtain data regarding every patient we register. These categories are dictated by the State of Georgia (please check one)

AMERICAN INDIAN / NATIVE ALASKAN AFRICAN AMERICAN ASIAN / PACIFIC ISLANDER WHITE OTHER: _____

IS THIS HOSPITAL VISIT DUE TO AN ACCIDENT OR INJURY? YES NO

IF YES, DATE OF ACCIDENT OR INJURY _____

IF ACCIDENT, PLEASE GIVE A BRIEF DESCRIPTION OF WHERE AND HOW THIS ACCIDENT HAPPENED

IF NOT RELATED TO AN ACCIDENT OR INJURY, DATE SYMPTOMS FIRST OCCURRED _____

REASON FOR VISIT _____

Provide a PHOTOCOPY ONLY of the following if applicable and check box if faxing/mailing with this registration.

- State or Federal Government issued drivers license or photo identification card if available
- Insurance identification card(s) for primary and secondary insurance if applicable
- Medicare identification card if applicable
- Advance Directive (Living Will or Durable Power of Attorney)
- Physician's Order

_____ Total Number of Pages Faxed/Mailed