WELLSTAR Medical Group

Patient Registration Form

1. Patient Information (Please complete all spaces)

Patient Last Name	First Name		Date of Birth	Age	Patient Gender ☐ M ☐ F
Street Address	City	State	Zip Code	Social Security Number	
Home Telephone ☐ check box if primary	Work Telephone ☐ check box if primary	Cell Telephone ☐ check box if primary	Email Address		
Need Interpreter? ☐ Yes ☐ No	Primary Language	Marital Status	Written Language	Ethnicity Hispanic or Latino? ☐ Yes ☐ No	Race	Religion
Activate MyChart ☐ Yes ☐ No	Employer Name		Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student		
Employer Address	City	State	Zip Code	Employer Telephone	
Emergency Contact Last Name	First Name		Pharmacy Telephone Number		
Emergency Contact Relation to Patient	Legal guardian? ☐ Yes ☐ No	Hearing Impaired? ☐ Yes ☐ No	Visually Impaired? ☐ Yes ☐ No	Home Telephone ☐ check if primary	Work Telephone ☐ check if primary	Cell Telephone ☐ check if primary
Primary Care Physician						

2. Responsible Party / Guarantor ☐ (Check if self and skip this section)

Guarantor Last Name	First Name	Guarantor Street Address	City	State	Zip Code
Guarantor Relation to Patient	Guarantor Gender ☐ M ☐ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone	
Guarantor Employer	Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student		Employer Telephone		

3. Medical Insurance Policy Holder ☐ (Check if self and skip this section)

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth
Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

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 WellStar Medical Group 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. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

Signature of Patient / Legal Guardian:	Date:

WELLSTAR Health System

Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly):*

Last Name *First Name* *Middle Initial* *Date of Birth (Month / Day / Year)*

Street Address *Apt. # / P.O. Box # (Please include complete mailing address)* *Medical Record # / Social Security # (optional)*

City *State* *Zip Code* *Primary Contact Number*

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

Business Number *Cell Phone Number* *Other Phone Number*

I authorize WellStar Health System to disclose Protected Health Information to the following persons:

☐ Spouse: _____
Name *Phone Number*

☐ Child(ren): _____
Name *Phone Number*

_____
Name *Phone Number*

☐ Other: _____
Name *Phone Number*

Information to be disclosed:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:

(date authorization signed by patient or Legal Guardian / Personal Representative) _____
Month / Day / Year

Print Patient Name or Name of Legal Guardian / Personal Representative ***Signature of Patient or Legal Guardian / Personal Representative***

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

WELLSTAR
Medical Group

Acknowledgment of Receipt

"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I have received a copy of WellStar Health System's ***"Notice of Privacy Practices"*** for protected health information on the date set forth below.

Date of Receipt

Patient Date of Birth

Print Patient Name

Print Name of Authorized Personal Representative

Patient Signature

Signature of Authorized Personal Representative

Please indicate relationship to patient

FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY

*(complete if patient acknowledgement is **not** obtained)*

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication / language or other barrier
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other (*please indicate reason*): _____

Signature of WellStar Representative

Date

WellStar Medical Group

Acknowledgment of Receipt of Notice of Privacy Practices