Promise Pediatrics
375 Boynton Drive
Ringgold, GA 30736

PATIENT REGISTRATION FORM

Date: _____ Acct #:_____

PERSON RESPONSIBLE FOR PAYING THE BILL			
Billing Name:			SS#:
Street Address:			
City:	State:	Zip:	Phone#:
Relationship to Patient:			DOB:
Employer Name:			
Street Address:			
City:	State:	Zip:	Phone#:
PATIENT INFORMATION			
Patient Name:			Acct #
Street Address:			
City:	State:	Zip:	Phone#:
DOB:	SS#:		Sex:
Employer Name:	Employer Phone#:		Marital Status:
Street Address:			
City:	State:	Zip:	
EMERGENCY INFORMATION (Outside Home)			
Emergency Contact Name:			
Street Addresss:			
City:	State:	Zip:	Phone#:
Employer:			
Street Address:			
City:	State:	Zip:	Phone#:
Relationship to Patient:			
PREFERRED PHARMACY			
Name of Pharmacy:			
Address/Location:		Phone #:	
REFERRAL SOURCE			
Who referred you to this office?			
☐ Friend/Relative ☐ Doctor ☐ Yellow Pages ☐ Media Ad ☐ Other:_____			

I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize the release of any medical information necessary to process insurance claims and certify that the information contained herein is correct.

Medicare patients: I authorize payment of Medigap benefits by the Medigap insurer as listed be made on my behalf to the provider or group, for services rendered.

Except under certain circumstances (Workers' Compensation; governmental programs such as Medicare or TN Care; and physician participating health insurance plans), I will be responsible for the full payment amount of the charges.

_____ _____

Signature of Patient/Responsible Person Date