

Chestatee Regional Hospital

Pre-Registration Form

Please complete all information and return to Central Scheduling prior to appointments. **Fax: 706.867.4174**

Procedure _____
Procedure Date _____ Physician _____
Admit Diagnosis/ Chief Complaint _____
Precert # _____ If maternity, Expected Date of Delivery _____

PATIENT INFORMATION

Patient Name _____ Birth Date _____ SSN _____
Mailing Address _____ City _____ State _____ Zip _____
Phone _____ Nearest Relative _____ Employer _____

PERSON RESPONSIBLE FOR BILL (IF PATIENT IS MINOR)

Patient Name _____ Birth Date _____ SSN _____
Street Address _____ City _____ State _____ Zip _____ Phone _____

INSURANCE INFORMATION

(This section does not need to be filled out if you provide a copy of current insurance card, both front and back. Without proof of insurance, your account will be considered a self-pay account and you will be responsible for all charges. Without verified insurance coverage, prior arrangements will have to be made with the hospital before services are performed.)

Insurance Carrier (primary) _____ Contract Number/SSN _____

Group # _____ Policy Holder's Name _____ Ins. Phone # _____

Employer _____ Employer's Phone # _____

Insurance Carrier (secondary) _____ Contract Number/SSN _____

Group # _____ Policy Holder's Name _____ Ins. Phone # _____

Employer _____ Employer's Phone # _____

Patient's Medicare # _____ Retirement Date-Pt _____ Spouse _____

Medicaid # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted for the hospital / physician to release any medical information that may be necessary for the completion of my hospital claims.

Signed _____ or nearest relative (Relationship) _____

Date _____ Witness _____ Date _____