Patient Registration Form

Commonwealth PRIMARY CARE
1614 Peachtree Parkway ▪ Suite #200 ▪ Cumming, GA 30041
Phone: **(678) 455-2295** Fax: **(678) 455-2279** **www.cummingprimarycare.com**

Patient Information

Date:_____

Legal Name: _____ Sex (M/F) : _____
Last First Middle Suffix

Date of birth: _____ SSN#: _____ Drivers License #: _____ State: _____

_____ ☐ Hispanic ☐ Non Hispanic _____ _____
Race Ethnicity Marital Status Preferred Language

Mailing Address: _____
City State Zip

Phone: _____ _____ _____ _____
Home Work Cell Email

Employment: _____ _____ _____ _____
Status Employer Name Employer Phone Occupation

Employer Address: _____
City State Zip

Preferred Pharmacy: _____ _____
Name Address

Insurance Information

☐ **Self-pay (no insurance)** ☐ **Insured**

Primary Insurance: _____ Subscriber: ☐ Self ☐ Spouse ☐ Other _____

Secondary Insurance: _____ Subscriber: ☐ Self ☐ Spouse ☐ Other _____

Guarantor: _____ _____ DOB: _____ SSN#_____
Legal Name Relation to Patient

Mailing Address: _____
City State Zip

Phone: _____ _____ _____ _____
Home Work Cell Email

Employment: _____ _____ _____ _____
Status Employer Name Employer Phone Occupation

Employer Address: _____
City State Zip

Emergency Contact Information

Emergency Contact: _____ _____ _____
Name (first, last) Phone Relation to Patient

Assignment of Benefits / Financial Policy

I authorize the release of any medical information to any insurance company, Medicaid Insurance, third party administrator, or other payer that is necessary to process the claim and request payment of benefits either to myself or to Commonwealth Primary Care, LLC. I understand that I am financially responsible for all charges, whether or not covered by insurance. Also, if my account has to be turned over to collections, I agree to pay all costs of collections including attorney fees.

_____ _____
Signature: Patient or Guardian Date