Esophageal Institute of Atlanta

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☉ Mr. ☐ Mrs. ☐ Ms.

Patient's Name (Last)_____ (First)_____ (Middle)_____

Social Security Number _____ ☐ Female ☐ Male Date of Birth _____
000 - 00 - 0000 *00 / 00 / 0000*

E-mail Address_____

Primary Phone No. _____ ☐ Cell ☐ Line Other Phone No. _____ ☐ Cell ☐ Line

Preferred Method of Contact ☐ Phone ☐ Text ☐ E-Mail

Address1 _____ Address2 _____

City _____ State_____ Zip _____

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship _____

Referring Physician Name_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____

Insurance Company_____ Phone Number _____

Subscriber ID (Policy Number) _____ Group ID _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____

Insurance Company_____ Phone Number _____

Subscriber ID (Policy Number) _____ Group ID _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____