Georgia Breast Care

Registration Form

TODAY'S DATE: _____ REFERRING PHYSICIAN: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB: ____/____/____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP : _____

PRIMARY CARE: _____ OB/GYN: _____

GENDER: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer SEX ASSIGNED AT BIRTH: ☐ Male ☐ Female

PRONOUNS THAT YOU PREFER WHEN TALKING WITH YOU: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other - Please specify: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ETHNICITY: ☐ Hispanic/Latin ☐ Not Hispanic/Latin

RACE: ☐ African-American ☐ Asian ☐ Hispanic ☐ Native American ☐ White ☐ Other: _____

LAST 4 DIGITS OF YOUR SOCIAL SECURITY #: ____ ____ ____ ____ OCCUPATION: _____

EMPLOYER NAME & ADDRESS: _____

HOME #: ( ) _____ CELL #: ( ) _____ WORK #: ( ) _____

May we leave a message on these contact numbers? ☐ yes ☐ no

EMAIL ADDRESS: _____

INSURANCE INFORMATION

☐ Check here if the person responsible for the bill is the ***SAME*** as above

POLICY HOLDER'S LAST NAME: _____ FIRST NAME: _____

LAST 4 DIGITS OF YOUR SOCIAL SECURITY #: ____ ____ ____ DOB: ____/____/____ SEX: ☐ Male ☐ Female

HOME #: ( ) _____ CELL #: ( ) _____ WORK #: ( ) _____

EMPLOYER NAME & ADDRESS: _____

PRIMARY INSURANCE NAME: _____ SUBSCRIBER'S NAME: _____

POLICY # _____ GROUP #: _____ CO-PAYMENT AMT: _____

RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY INSURANCE NAME *(if applicable)*: _____ SUBSCRIBER'S NAME_____

POLICY # _____ GROUP #: _____ CO-PAYMENT AMT: _____

RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

IN CASE OF EMERGENCY

NAME OF CONTACT: _____ RELATIONSHIP TO PATIENT: _____ CONTACT #: _____

The above information is true to the best of my knowledge. We will file insurance with your provider according to your individual plan.

_____ _____

PATIENT SIGNATURE OR AUTHORIZED SIGNATURE DATE