DeKalb Medical

PATIENT PRE-REGISTRATION FORM

Please complete as much of the following information as possible in order to expedite the pre-registration process.

I.PATIENT INFORMATION

Last Name	First Name	Middle Name	**Maiden Name**

Street Address	Apt No.	City	State	Zip	County	Home Phone

Birth Date	Birthplace **(State)**	Sex	Race	Social Security No.	Marital Status	Occupation

Employer Name	Employer Address	Employer Phone

Father's Name	Father's Birthplace (State)	Mother's **Maiden Name**	Mother's Birthplace (State)

II. SPOUSE INFORMATION

Last Name	First Name	Middle Name	Street Address	Apt No.	City	State	Zip

Home Phone	Social Security No.	Birth Date	Occupation	Employer Name

Employer Address	Employer Phone

III. GUARANTOR INFORMATION (Person responsible for payment of the account)

Relationship to Patient	Last Name	First Name	Middle Name	Birth Date	Social Security Number

Street Address	Apt No.	City	State	Zip	Home Phone

Occupation	Employer Name	Employer Address	Employer Phone

IV. EMERGENCY CONTACT INFORMATION (Someone not residing in same household)

Relationship to Patient	Last Name	First Name	Middle Name

Street Address	Apt No.	City	State	Zip	Home Phone	Work Phone

V. INSURANCE INFORMATION (List all insurance plans you will be using to cover your hospital visit)

Name of Insurance Co. #1	Name of Policyholder	Relationship to Patient	Policy No.

Insurance Company Address (Where to mail claim to)	Group No.

Does the insurance require precertification? Yes__ No__ (Look on insurance card)	Precertification phone # on card	Verification phone # on card

Name of Insurance Co. #2	Name of Policyholder	Relationship to Patient	Policy No.

Insurance Company Address (Where to mail claim to)	Group No.	Precertification Authorization #

Does the insurance require precertification? Yes__ No__ (Look on insurance card)	Precertification phone # on card	Verification phone # on card

VI. MISCELLANEOUS INFORMATION

Primary Care Physician (PCP) name	PCP Phone Number	Referring Physician's Name	Referring Physician's Phone Number

Test/Surgery/Admission Date	Reason for Test Surgery/Admission (Symptoms/Diagnosis)	Date Symptoms Began

Religion	Room Preference (Admission Only) Private ___ Semi-Private ___	Have you been a patient here before? Yes ___ No ____	Date of Last Test/Admission

Please remember that any amount not covered by insurance is due at time of dismissal. For preadmission financial counseling, please call 404-501-5157.