

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)

New Patient Information (MALE)
Patient Registration Date _____

Patient's Full Name _____ Patient's Nickname/AKA _____
(Last Name) (First Name) (Middle Initial)

Patient's Social Security No. (required field) _____ Cell Phone# () _____

Email address _____ Permission to email Yes ___ No ___

Address I:(Street Address) _____ : (PO Box, Apt, Ste #) _____

City _____ County _____ State _____ Zip _____ Home Ph # () _____

Birthdate _____ Sex M or F _____ Race _____ Marital Status _____

Patient's Employer _____ Address _____

City _____ State _____ Zip _____ Patient's Employer Phone No () _____

Partner/Spouse: Name _____ Birthday _____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Address _____ City _____ State _____ Zip _____

Emergency Contact Phone No (864) _____ Emergency Contact Employer _____

Employer Phone No. (864) _____

This is the person responsible for the balance after insurance pays on the account.
"If 18 or older, you are your own guarantor and do not have to fill out this section."

Guarantor Name _____ Guarantor Phone No. _____ Relationship to Patient _____

Guarantor Social Sec No. _____ Guarantor Address _____

City _____ State _____ Zip _____ Guarantor Employer _____

Address _____ City _____ State _____ Zip _____

Guarantor Employer Phone No. _____

Is visit result of liability accident? () Yes () No (Examples: auto accident, workers compensation, etc.)

If you checked "Yes" to this question, return to the receptionist for additional form

AUTHORIZATION: I will be responsible for any amount not covered by insurance. I authorize _____ to provide medical evaluation and treatment, and release information for Insurance/medical purposes concerning my illness and treatment.

Signature of Authorized Person: _____ Date: _____

METHOD OF PAYMENT FOR VISIT TODAY, PLEASE CHECK ONE:

CASH _____ CHECK _____ CREDIT CARD _____ DEBIT CARD _____