YourTown Health

PATIENT REGISTRATION 2025

Patient Name: _____ **Social Security Number**: _____-_____-_____
Date of Birth: _____/_____/_____ **Marital Status:** Single___ Married____ Divorced___ Widow___ **Veteran?** Yes No
Male_____ Femme _____

Address_____ Zip Code _____
Home Phone (_____) _____ **Cell Phone** (_____) _____
Email Address _____ **[ ] I wish to sign up for the Patient Portal**
☐ Do not have email ☐ Will not disclose email

Asian American Indian/Alaskan Native African American Hawaiian Pacific Islander White Decline to Specify

Spanish Origin Not Spanish Origin Decline to Specify

Preferred Language (circle one): English Spanish Other: _____

Employer Name _____ Employer Address _____
Primary Care Physician _____ Phone Number _____
How did you hear about our Practice? _____
Do you have medical or dental insurance? Yes _____ No _____ If yes, please present your insurance card.

Person responsible for bill or parent (Complete section only if different from patient)
Guarantor Name _____ Social Security Number _____-_____-_____
Relationship to Patient :(circle one) Self Spouse Parent Date of birth of Guarantor _____/_____/_____
Address_____Phone Number_____
Employer Name_____Address_____
Who to call for an emergency (list 2 contacts)
Name_____ Relationship _____
Home Phone _____ Cell Phone _____
Name _____ Relationship _____
Home Phone _____ Cell Phone _____

Georgia Advanced Directive ☐ Yes ☐ No ☐ Not Applicable
Preferred Pharmacy _____ **Phone Number** _____

First Insurance Information
Plan Name _____ ID Number _____
Address _____ Group Number _____
Policy Holder _____ Effective Date _____
Policy Holder's Social Security Number_____
Second Insurance Information
Plan Name _____ ID Number _____
Address _____ Group Number _____
Policy Holder _____ Effective Date_____
Policy Holder's Social Security Number_____
IS YOUR VISIT DUE TO A JOB-RELATED INJURY OR AUTOMOBILE ACCIDENT? YES_____ NO _____
If yes, please notify the receptionist.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS BILL TO MY INSURANCE COMPANY, AND REQUEST PAYMENT OF BENEFITS TO PALMETTO HEALTH COUNCIL, INC. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT WHETHER OR NOT COVERED BY INSURANCE. I ALSO AUTHORIZE THE HEALTHCARE STAFF TO PERFORM ALL NECESSARY SERVICES REQUIRED FOR TREATMENT.

Signature_____Date_____