PATIENT REGISTRATION

Date:			Chart #: *Office use only)*
Name:			
Address:			
City:	GA	Zip Code:	
Phone #:		Cell Phone #	
Social Security #:		Email:	
Date of Birth:	Age:		Married: ❑ Yes ❑ No

Reason for your visit:	
If you are pregnant, when was the first day of your last menstrual period?	
If you are pregnant, have you had any prenatal care? ❑ Yes ❑ No	
Name of Clinic or office:	
Name of Doctor:	
Address:	
City:	State:
Phone #:	

Form of payment: ❑ Cash ❑ Medicaid ❑ Insurance *(if you have health insurance coverage, please provide the following information about the insurance carrier)*	
Name:	
Date of Birth:	Social Security #:
Employer:	Employer's phone #:

In case of any emergency, whom should we contact?	
Name:	
Address:	
Phone #:	Relationship:

How did you hear about us?			
	❑ Mundo Hispanico ❑ Internet ❑ Facebook ❑ Twitter ❑ Instagram ❑ CIMA website	❑ Friend ❑ Que Pasa en Atlanta ❑ Previous Patient ❑ Zoc Doc ❑ Postcard ❑ Other Practice/organization referral ______________________________	❑ Health Fair ❑ Flyer ❑ Other ______________________________

I understand the cost for my prenatal care and agree to pay this amount to CIMA.

Signature ____