Rockdale Medical Center
www.rockdalemedicalcenter.org

Dear Mother to Be,

Thank you for choosing Rockdale Medical Center for your future delivery. We are honored to be a part of this time of your life.

This form is a pre-registration form to be completed and returned to Rockdale Medical Center. Please complete the form fully to insure we have all of your information and to reduce your admission time when you need to come in for an OB check or for delivery. If you need assistance completing this form please contact LDRP Admissions office at 770-918-3670.

Once you have completed this form:

Mail to: Patient Registration 1412 Milstead Ave. Conyers, GA 30012 or

Fax 770-918-3642

Please include a copy of your photo ID

Please include a front and back copy of your insurance card

If you are uninsured we have on-site financial counselors that may be able to get financial assistance for your visits to the hospital. Please call 770-918-3823.

You can also complete this pre-registration form online and have a confirmation e-mail sent to you once your pre-registration has been completed by going to http://www.rockdalemedicalcenter.org/patients-visitors/pre-registration

Thank you,

Rockdale Medical Center

Patient Access Services

770-918-3670

Rockdale
Medical Center

Patient Name: _____
Last Name, First Name MI

Birthdate: _____ Age: _____ Sex: _____

Street Address: _____

City: _____

State: _____ Zip Code _____

Phones: Home: _____ Other: _____

Marital Status: _____ Race: _____

Social Sec #: _____

Religion: _____

Employer Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Emp Phone: _____

Pt Occup: _____

Emp Status: _____

Next of Kin

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phones: Home: _____ Other: _____

Rel to Pt: _____

Person to Notify

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phones: Home: _____ Other: _____

Rel to Pt: _____

Guarantor

Name: _____

Street Address: _____

City: _____

State _____ Zip Code: _____

Home Phone: _____

Social Sec#: _____

Rel to Pt: _____

Guarantor's Employer

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Occup: _____

Emp Status: _____

Rockdale
Medical Center

Patient Name: _____
Last Name, First Name MI

Insurance 1:

Name: _____ Policy #: _____

Street Address: _____ Group Name: _____

City: _____ Group #: _____

State: _____ Zip Code: _____ Emp Status: _____

Phone: _____ Emp Name: _____

Subscriber: _____ Rel to Pt: _____
Last Name, First Name MI

Street Address: _____ Date of Birth: _____ Sex: _____

City: _____ Social Sec #: _____

State: _____ Zip Code: _____ Marital Status: _____ Race: _____

Phone: _____

Insurance 2:

Name: _____ Policy #: _____

Street Address: _____ Group Name: _____

City: _____ Group #: _____

State: _____ Zip Code: _____ Emp Status: _____

Phone: _____ Emp Name: _____

Subscriber: _____ Rel to Pt: _____
Last Name, First Name MI

Street Address: _____ Date of Birth: _____ Sex: _____

City: _____ Social Sec #: _____

State: _____ Zip Code: _____ Marital Status: _____ Race: _____

Phone: _____

Rockdale Medical Center

Patient Name: _____
Last Name, First Name MI

Advance Directives:

Do you have a living will?	Yes	No		
Do you have a healthcare power of attorney?	Yes	No		
If yes, has a copy been provided to RMC?	Yes	No	If yes, date provided:	_____
If no, will a copy be provided?	Yes	No	If yes, date provided:	_____

General Consent:

Do you consume tobacco products?	Yes	No

Physician: _____

Reason for Visit: _____

Date of Appointment: _____