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 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 770-918-3675.

Once you have completed this form:

> **Mail to: Patient Registration 1412 Milstead Ave. Conyers, Ga 30012 or Fax 770-761-7531**
> **Please include a copy of your photo id**
> **Please include a copy of current insurance card(s) (front and back of the card)**

If at the time you complete this form you are uninsured please be advised 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.

Thank you

Rockdale Medical Center
Patient Access Services
770-918-3675

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:

Patient Name: ______________________
Last Name, First Name MI

Insurance 1:

Name: ______________________

Street Address: ______________________

City: ______________________

State: __________ Zip Code: __________

Phone: ______________________

Subscriber: ______________________
Last Name, First Name MI

Street Address: ______________________

City: ______________________

State: __________ Zip Code: __________

Phone: ______________________

Policy #: ______________________

Group Name: ______________________

Group #: ______________________

Emp Status: ______________________

Emp Name: ______________________

Rel to Pt: ______________________

Date of Birth: __________ Sex: __________

Social Sec #: ______________________

Marital Status: __________ Race: __________

Insurance 2:

Name: ______________________

Street Address: ______________________

City: ______________________

State: __________ Zip Code: __________

Phone: ______________________

Subscriber: ______________________
Last Name, First Name MI

Street Address: ______________________

City: ______________________

State: __________ Zip Code: __________

Phone: ______________________

Policy #: ______________________

Group Name: ______________________

Group #: ______________________

Emp Status: ______________________

Emp Name: ______________________

Rel to Pt: ______________________

Date of Birth: __________ Sex: __________

Social Sec #: ______________________

Marital Status: __________ Race: __________

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: ______________________________