EMORY HEALTHCARE

THE EMORY CLINIC, INC.

DOWNTIME REGISTRATION FORM
New Patient Form

* denotes required field

For Office Use Only:

TEC MRN #: _____

Appointment Date/ Time: _____

Emory Clinic Physician: _____

Patient EMPI #: _____

Patient CPI #: _____

PATIENT INFORMATION

Last Name* | First Name* | Middle Name | Patient Suffix

Patient Gender* | Patient Birth Date* | Patient Marital Status | Patient Mother's Maiden Name

*Please provide **one of the following unique identifiers.** (Not applicable to minors, under age 18) **

Driver's License (or State ID) # and State | Patient Passport/ VISA ID # | Patient Military # | Social Security #

PATIENT CONTACT INFORMATION

Patient Home Address

Country* | Street Address* | Street Address2

City* | State* | Zipcode*

Patient Billing Address (if same as above, please check) ☐

Country | Street Address | Street Address2

City | State | Zipcode

Home Phone* | Cell Phone | Email Address | Preferred Method of Contact

Additional Patient Demographic Information

Primary Language for Care | Interpreter Required? ☐ Yes ☐ No | Patient Race | Patient Ethnicity ☐ Hispanic or Latino ☐ Non-hispanic or Non-Latino ☐ Other

INSURANCE INFORMATION

Primary Insurance

Are you the policy holder? ☐ Yes ☐ No If uninsured, please check: ☐

Primary Payor Name* | Primary Health Plan Name* | Primary Insurance Network*

Effective Date | Member ID* | Subscriber ID*