

Winder Internal Medicine and Geriatrics Center P.C.

20 Satellite Dr. Ste 100, Winder, GA 30680

Phone (770) 586-0310, Fax (770) 586-0312

Registration Form

Patient Information

Name _____ Gender Male Female
Last First Middle

Date of Birth ____ / ____ / ____ Social Security # _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail _____

Marital Status: Married Single Widow Divorced Other _____

Employment Full Time Part Time Student Retired Other _____ Employer _____

Emergency Contact _____ Relation _____

Phone: Home _____ Work _____ Cell Phone _____

Pharmacy Information

Name _____ Phone _____ Fax _____

Address _____
Street City State Zip

Primary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Policy Holder _____ Relation to Patient _____ Date of Birth _____
Last First MI

Social Security # _____ Phone _____

Secondary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Responsible Party: If other than Patient, Please Complete

Person to bill _____ Relation to Patient _____ Social Security # _____
Last First MI

Address _____
Street City State Zip

Phone: Home _____ Work _____ Cell Phone _____