



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**



Street Address: _____

City: _____

State: _____ Zip Code _____

Phones: Home: _____ Other: _____

Marital Status: _____ Race: _____

Social Sec #: _____

Religion: _____

Next of Kin

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: _____

Patient Name: _____
Last Name, First Name MI

Birthdate: _____ Age: _____ Sex: _____

Employer Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Emp Phone: _____

Pt Occup: _____

Emp Status: _____

Person to Notify

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phones: Home: _____ Other: _____

Rel to Pt: _____

Guarantor's Employer

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Occup: _____

Emp Status: _____



Insurance 1:

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Subscriber:

Last Name, First Name MI

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Insurance 2:

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Subscriber:

Last Name, First Name MI

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Patient Name:

Last Name, First Name MI

Policy #: _____

Group Name: _____

Group #: _____

Emp Status: _____

Emp Name: _____

Rel to Pt: _____

Date of Birth: _____ Sex: _____

Social Sec #: _____

Marital Status: _____ Race: _____

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: _____