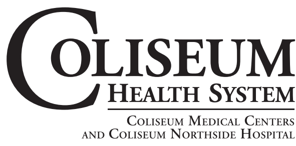

PRE-REGISTRATION INFORMATION

Check box for facility where treatment is to be performed

If you would prefer to register online, please go to
www.coliseumhealthsystem.com

☐ **COLISEUM MEDICAL CENTERS**
Attn: Patient Access
350 Hospital Drive
Macon, Georgia 31217
Phone: (478) 464-1638 or 464-1286
Fax: (478) 464-1515

☐ **COLISEUM NORTHSIDE HOSPITAL**
Attn: Patient Access
400 Charter Boulevard
Macon, Georgia 31210
Phone: (478) 757-5963
Fax: (478) 757-5946

DATE OF TREATMENT	TYPE OF TREATMENT (I.E. LAB, SURGERY, X-RAYS, INPATIENT)	PHYSICIAN'S NAME

PATIENT INFORMATION *(PLEASE PRINT CLEARLY)*

PATIENT'S LEGAL NAME (LAST) (FIRST) (MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE
PATIENT'S HOME ADDRESS (STREET) (CITY / STATE) (ZIP)			HOME PHONE NO. W/ AREA CODE ( )
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGAL SEP. ☐ UNKNOWN	PRIMARY LANGUAGE	RELIGIOUS PREFERENCE	STUDENT STATUS ☐ FULL-TIME ☐ PART-TIME
PATIENT'S EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ ACTIVE MILITARY	PATIENT'S EMPLOYER PHONE NO. W/ AREA CODE ( )		OCCUPATION
EMPLOYER'S NAME & ADDRESS (STREET) (CITY / STATE) (ZIP)			

RESPONSIBLE PARTY *(IF UNDER AGE 18, LIST PARENT INFORMATION)*

RESPONSIBLE PARTY'S NAME (LAST) (FIRST) (MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATION TO PATIENT
RESPONSIBLE PARTY'S HOME ADDRESS (STREET) (CITY / STATE) (ZIP)			HOME PHONE NO. W/ AREA CODE ( )
RESPONSIBLE PARTY'S EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ ACTIVE MILITARY	RESPONSIBLE PARTY'S EMPLOYER PHONE NO. W/ AREA CODE ( )		OCCUPATION
EMPLOYER'S NAME & ADDRESS (STREET) (CITY / STATE) (ZIP)			

OTHER RESPONSIBLE PARTY *(PARENT CARRYING SECONDARY COVERAGE OR SPOUSE IF SPOUSE IS INSURED)*

OTHER RESPONSIBLE PARTY'S NAME (LAST) (FIRST) (MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATION TO PATIENT
OTHER RESPONSIBLE PARTY'S HOME ADDRESS (STREET) (CITY / STATE) (ZIP)			HOME PHONE NO. W/ AREA CODE ( )
OTHER RESPONSIBLE PARTY'S EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ ACTIVE MILITARY	OTHER RESPONSIBLE PARTY'S EMPLOYER PHONE NO. W/ AREA CODE ( )		OCCUPATION
EMPLOYER'S NAME & ADDRESS (STREET) (CITY / STATE) (ZIP)			

INSURANCE INFORMATION

NAME OF **PRIMARY** INSURANCE		NAME OF **SECONDARY** INSURANCE	
NAME OF INSURED PERSON	RELATIONSHIP TO PATIENT	NAME OF INSURED PERSON	RELATIONSHIP TO PATIENT
INSURED PERSON'S EMPLOYER	INSURED'S DATE OF BIRTH	INSURED PERSON'S EMPLOYER	INSURED'S DATE OF BIRTH
POLICY, CERTIFICATE OR ID NUMBER	GROUP NUMBER	POLICY, CERTIFICATE OR ID NUMBER	GROUP NUMBER
INSURANCE ADDRESS, CITY / STATE, ZIP		INSURANCE ADDRESS, CITY / STATE, ZIP	
PHONE NO. W/ AREA CODE ( )	EFFECTIVE DATE OF COVERAGE	PHONE NO. W/ AREA CODE ( )	EFFECTIVE DATE OF COVERAGE

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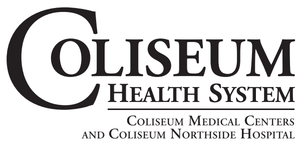

PRE-REGISTRATION INFORMATION

(Continued — page 2)

MEDICARE *(IF APPLICABLE)*

MEDICARE NUMBER	PART A ☐ YES ☐ NO	PART A EFFECTIVE DATE	PART B ☐ YES ☐ NO	PART B EFFECTIVE DATE
HAS THE PATIENT BEEN HOSPITALIZED OVERNIGHT IN THE LAST 60 DAYS? ☐ YES ☐ NO	IF YES, WHICH HOSPITAL?			
PATIENT'S RETIREMENT DATE	SPOUSE'S RETIREMENT DATE	ARE YOU CURRENTLY RECEIVING HOSPICE OR HOME HEALTH SERVICES? ☐ YES ☐ NO	IF YES, NAME OF COMPANY	

EMERGENCY NOTIFICATION AND NEXT OF KIN INFORMATION

NAME			RELATION TO PATIENT	HOME PHONE NO. W/ AREA CODE ( )
ADDRESS (STREET)	(CITY / STATE)	(ZIP)		WORK PHONE NO. W/ AREA CODE ( )

MISCELLANEOUS INFORMATION

We are required by the State of Georgia to obtain data regarding every patient we register. These categories are dictated by the State of Georgia *(please check one)*

☐ AMERICAN INDIAN / NATIVE ALASKAN ☐ AFRICAN AMERICAN ☐ ASIAN / PACIFIC ISLANDER ☐ WHITE ☐ OTHER:____________________

IS THIS HOSPITAL VISIT DUE TO AN ACCIDENT OR INJURY? ☐ YES ☐ NO	IF YES, DATE OF ACCIDENT OR INJURY
IF ACCIDENT, PLEASE GIVE A BRIEF DESCRIPTION OF WHERE AND HOW THIS ACCIDENT HAPPENED	
IF NOT RELATED TO AN ACCIDENT OR INJURY, DATE SYMPTOMS FIRST OCCURRED	REASON FOR VISIT

Provide a PHOTOCOPY ONLY of the following if applicable and check box if faxing/mailing with this registration.

☐ State or Federal Government issued drivers license or photo identification card if available

☐ Insurance identification card(s) for primary and secondary insurance if applicable

☐ Medicare identification card if applicable

☐ Advance Directive (Living Will or Durable Power of Attorney)

☐ Physician's Order

_________**Total Number of Pages Faxed/Mailed**