KINGDOM
CARDIOVASCULAR CARE & WELLNESS CENTER

8687 Hospital Drive, Suite 102, Douglasville, GA 30134 | 6853 Douglas Blvd Ste C, Douglasville, GA 30135
Phone: 678.785.5001 | https://kccwc.com

REGISTRATION FORM

Section I: Patient Information Date_____

Physician Name: _____

Name: _____ I prefer to be called: _____

Address: _____City:_____State:_____Zip:_____

Phone (_____) _____¬_ Work Phone (_____) _____ Cell Phone (_____) _____

The best time to contact me is: _____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell

Email Address_____

Date of Birth: _____¬_____ Social Security Number: _____

Will you require an interpreter? ☐ Yes ☐ No Native Language: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐Married ☐ Widowed ☐ ☐ Separated ☐ Divorced

Preferred Pharmacy Name and Number:_____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Your preferred pharmacy's name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SECTION II—(If not Primary Insured)

Relationship to Patient: ☐ Self ☐Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone:
(____)_____

Employer_____ Work Phone (____) _____

SSN#_____

PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID. PAYMENT IS EXPECTED AND APPRECIATED AT TIME OF SERVICES.