

OB/GYN HEALTH CENTER REGISTRATION FORM

(Please Print)

Today's date: _____

| PATIENT INFORMATION | | | |
|--|-------------|--|---|
| Patients Name: (last --- first --- middle initial) | | <input type="checkbox"/> Female <input type="checkbox"/> Male | Marital status (circle one) Single / Mar / Div / Sep / Wid |
| Birth date: | Age: | Social Security: | |
| Street address: | | City: | State |
| | | Zip Code: | |
| Cell Phone: | Home Phone: | Email: | |
| Occupation: | Employer: | Employer Phone Number: | |
| Referring Doctor: | | Primary Care/ Family Doctor: | |
| Pharmacy: | | Phone Number: | |
| INSURANCE INFORMATION | | | |
| Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian | | | |
| Insured/ Responsible Party: | | Birth date: | |
| Phone Number: | | Employer: | |
| Name of insurance: | | Policy Number: | |
| Group Number: | | Phone Number: | |
| IN CASE OF EMERGENCY | | | |
| Name: | | Relationship to patient: | Phone Number: |
| <p>ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all of my collection and attorney fees.</p> | | | |
| Patient/Guardian signature: | | | Date: |

How did you hear about us? _____ Friend/ family member _____ Internet search

Other: _____