OB/GYN HEALTH CENTER

REGISTRATION FORM

(Please Print)

Today's date:_______________________________

PATIENT INFORMATION					
Patients Name: (last --- first --- middle initial)			Preferred Name:		☐ Female ☐ Male
Birth date:	Age:	Social Security:			
Street address:			City:	State	Zip Code:
Cell Phone:	Home Phone:		Email:		
Employer:	Employer Phone Number:			Occupation:	
Pharmacy:		Pharmacy Phone Number / Address:			
Previous GYN: (In the Last 3 Years) ____________________ ____________________ First Name Last Name Phone #:		Primary Care/ Family Doctor: ____________________ ____________________ First Name Last Name Phone #:			

INSURANCE INFORMATION	
Relationship to patient: ☐self ☐spouse ☐parent ☐guardian	
Insurance Company Name:	Member ID #:
Group Number:	Phone Number:
Name of Policy Holder:	Date of Birth of Policy Holder:

IN CASE OF EMERGENCY		
Name:	Relationship to patient:	Phone Number:

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.

Patient/Guardian signature:	Date: