Patient Registration **PALM BEACH WOMEN'S CARE.**

PATIENT INFORMATION:

Name____ Date of Birth _______________ [ ]S [ ]M [ ]W [ ]D [ ]Sep

Address____ City____________________ ST_______ ZIP _________

Home Telephone ___________________Cellular Telephone ___________________Work Telephone_____________

Social Security # XXX-XX-_______________(only last 4 digits)

E-Mail Address____________________________________

What pharmacy do you use?_____________________ Pharmacy Phone Number_________________________

Permission for office to obtain pharmacy records? Yes___ No___

Permission for office to obtain hospital records? Yes___ No___

*If unable to keep appointment, please give 24 hours notice to avoid a $25 charge

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EMERGENCY CONTACT:

Name ____ Telephone___________________________

Relationship to Patient__________________________

Primary Insurance Company ____

Subscriber Name _______________________________________ Policy Number __________________________

Secondary Insurance Company _______________________________________

Subscriber Name _______________________________________ Policy Number __________________________

***If patient is a minor please provide the following information**:

Guardian's Name___________________________ Guardian's Phone Number __________________________

Guardian's Date of Birth_______________ Social Security # XXX-XX-_________ (Only last 4 digits)

ASSIGNMENT OF BENEFITS – AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize payment of medical and/ or surgical benefits to PALM BEACH WOMEN'S CARE for services rendered by the physicians or under their supervision. I also authorize PALM BEACH WOMEN'S CARE to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of these assignments shall be valid as the original. I understand that I am financially responsible for services rendered. Failure to pay any balance due in a timely manner may result in reporting the account to a collection agency. The undersigned patient or responsible party will be responsible for all collection and attorney fees if the account is placed with a collection agency.

MEDICARE – MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Patient Signature ____ **Date** ________________

Responsible Party/Parent/Guardian Signature ____