Dr. Xiao-Mei Zeng
OBSTETRICS & GYNECOLOGY

TopLine MD Alliance

PATIENT REGISTRATION FORM

Patient Information

Name:_____ **Date of Birth:**_____
First, Middle and Last name as it appears on insurance card

Sex: ❍ Male ❍ Female **Social Security Number:**_____

Marital Status: ❍ Single ❍ Married ❍ Widow ❍ Divorced ❍ Other:_____

Race/Ethnicity: ❍ Asian ❍ Black ❍ Hispanic ❍ Pacific Islander ❍ White ❍ Other:_____

Check one: ❍ Employed ❍ Retired ❍ Full-Time Student ❍ Other:_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Cell Phone:**_____

Email Address:_____

Primary Care Physician:_____ **Phone:**_____

How did you hear about us?

❍ Our Website ❍ Insurance website or list ❍ Referred by Doctor_____

❍ Newspaper ❍ Mailing (letter or postcard) Doctor Phone #_____

❍ Radio ❍ Another patient (family or friend) ❍ Other_____

Insurance Information

Please provide your insurance card to the receptionist

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Worker's Compensation ❍ Other:_____

Insurance Company: _____

Insured/Card Holder's Name:_____ **Birthdate:**_____

Relationship:_____ **Phone #:**_____

Policy #:_____ **Group #:**_____

Secondary Insurance Information

Please provide your insurance card to the receptionist

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Worker's Compensation ❍ Other:_____

Insurance Company: _____

Insured/Card Holder's Name:_____ **Birthdate:**_____

Relationship:_____ **Phone #:**_____

Policy #:_____ **Group #:**_____

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PATIENT REGISTRATION FORM *cont.*

Emergency Contact

Name:_____ Sex: ❍ Male ❍ Female
First, Middle and Last Name

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Social Security Number:_____

Pharmacy

Pharmacy Name:_____ Phone #:_____

Pharmacy Address:_____

Spouse/Guarantor/Responsible Party

Name:_____ Date of Birth:_____
First, Middle and Last Name

Sex: ❍ Male ❍ Female Relationship:_____

Daytime Phone:_____ Social Security Number:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Employer Name: _____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Your appointment time has been set aside for you alone; no other patients are scheduled at the same time. If you can't keep it, kindly cancel in advance. There will be a $ charge for missed appointments. Initials:_____

I hereby authorize payment, directly to Boca Delray Women Care, LLC of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work and vaccines not covered by my insurance contract as performed in the office, and for any co-payments and/or deductible amounts as specified in my insurance contract. I acknowledge that Private Health Information material (HIPAA) is posted, and available upon request.

Patient Name _____ Signature _____ Date _____