Partners In Women's Health, P.C.

Patient Registration Form

Date: _____ Please complete ALL questions on this form – Insert "N/A" for items that do not apply

PATIENT INFORMATION

NAME _____ NAME YOU PREFERRED TO BE CALLED _____
LAST FIRST INITIAL

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ SSN _____ MARITAL STATUS _____

HOME NUMBER _____ WORK NUMBER _____ CELL NUMBER _____

EMPLOYER NAME _____ OCCUPATION _____

EMERGENY CONTACT NAME _____ CONTACT NUMBER _____ RELATIONSHIP _____

PRIMARY CARE PHYSICIAN (FULL NAME) _____ PHONE NUMBER _____

WHOM MAY WE THANK FORM REFERRING YOU TO OUR OFFICE? _____

BILLING INFORMATION

INSURANCE COMPANY NAME _____ ID # _____ GROUP # _____

NAME OF POLICY HOLDER _____ RELATIONSHIP _____ DATE OF BIRTH _____
LAST FIRST INITIAL

HOME ADDRESS (IF DIFFERENT) _____ CITY _____ STATE _____ ZIP _____

EMPLOYER NAME _____ SSN _____

ARE YOU COVERED BY ANY OTHER HEALTH INSURANCE? ☐YES ☐NO (IF YES, PLEASE COMPLETE THE INFORMATION REQUESTED BELOW)

NAME OF INSURANCE _____ ID # _____ GROUP/PLAN # _____

POLICYHOLDER NAME _____ RELATIONSHIP _____
LAST FIRST INTIAL

DATE OF BIRTH _____ SSN _____ EMPLOYER NAME _____

Consent to Treat

By signing below, I attest that I am the above named patient and authorize Partners in Women's Health, P. C. to provide care and treatment.

Authorization to Bill Insurance

I certify that I am covered under the above stated insurance policy, and assign all insurance benefits directly to Partners In Women's Health, P.C. I also understand that I am financially responsible for all charges incurred, including all charges denied by my insurance company, for any reason. I agree to pay any amount and all costs and expenses incurred in collecting any unpaid balance owed. I hereby authorize Partners In Women's Health, P.C., to release any clinical or personal information necessary to secure payment of medical claims. I authorize the use of this signature on all insurance submissions. I understand that applicable copays, coinsurance, deductibles and all non-covered services are payable at the time services are rendered unless prior arrangements have been made.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature, if Patient is a Minor Date