Dr. _____ **Patient Registration** Acct # _____

Patient Name _____
(First) (Middle) (Last)

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

DOB _____ Age _____ Marital Status _____

Social Security # _____ Email _____

Employer Name _____ Occupation _____

Employer Address _____ City _____

Please Notify in case of emergency _____ Phone # _____

Whom may we Thank for referring you? _____ Primary Physician _____

SPOUSE/PARENT'S INFORMATION

Name _____ Name _____

Relationship to Parient _____ Relationship to Parient _____

SS# _____ DOB _____ SS# _____ DOB _____

Driver's License # _____ Driver's License # _____

Address _____ Address _____

Home Phone _____ Work _____ Home Phone _____ Work _____

Employer _____ Employer _____

INSURANCE INFORMATION IF NEW INSURANCE, PREVIOUS INSURANCE TERM DATE _____

Primary Insurance Co. _____ **Copay** _____ **Effective** _____

Address _____ Phone # _____

Certificate/ID # _____ Group/Plan # _____

Group/Employer Name _____

Insured's Name _____ DOB _____ Relationship to Patient _____

Secondary Insurance Co. _____

Address _____ Phone # _____

Certificate/ID # _____ Group/Plan # _____

Group/Employer Name _____

Insured's Name _____ DOB _____ Relationship to Patient _____

CONSENT TO TREATMENT: I hereby grant permission to the Physician in charge of my case and such Assistants as he or they may designate, to perform and administer all treatments and diagnosis, which in their judgment may be considered necessary or advisable for the patient's well being.

RELEASE OF INFORMATION: I hereby authorize Women's Health Medical Group or Associate in charge of my care to release information contained in my medical records to the insurance company or companies, agents or independent contracts thereof, fort the purpose of processing my claims for insurance benefits.

FINANCIAL AGREEMENT: The undersigned hereby agrees that in consideration for services rendered, payment of the accounts is guaranteed in accordance to the regular rates and terms of Women's Health Medical Group. The Undersigned clearly understands that payment obligation is the responsibility of the patient and or undersigned.

ASSIGNMENT OF BENEFITS: I hereby assign to Women's Health Medical Group or Associate associated with my care and treatment any interest and benefits provided under my insurance policy or policies. I also understand that any balance not covered by insurance are due and payable by myself.

_____ _____ _____
PATIENT OR REPRESENTATIVE RELATION WITNESS DATE