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 ____________________

Relationship to Parient ____________________

SS# ____________________ DOB __________

Driver's License # ____________________

Address ____________________

Home Phone __________ Work __________

Employer ____________________

Name ____________________

Relationship to Parient ____________________

SS# ____________________ DOB __________

Driver's License # ____________________

Address ____________________

Home Phone __________ Work __________

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