Healthy Woman
Obstetrics Gynecology

Patient Registration Form

Today's Date: ____ /____ /_____
Last Name:_____ First Name:_____ Middle:_____
Address:_____APT#_____
City_____ State:_____ Zip_____
Home Ph: (_____) _____ Work Ph: (_____) _____ Other Ph: (_____)_____
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ / _____ / _____ Age:_____
Status: Single Married Widow Divorced Sex: Male Female Occupation:_____
Employer: _____ Employer Phone:(_____) _____
Emergency Contact Person: _____ Phone: (_____) _____

Insurance Information

(If insurance information is incorrect or incomplete, the patient will be responsible for bill)

Primary Insurance Name:_____Phone: (_____) _____
Address: _____ City/State _____ Zip_____
Subscriber Name:_____ Employer:_____
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ____ / ____ / ____ Relationship to patient_____
ID#:_____ Group #:_____

Secondary Insurance Name:_____Phone: (_____) _____
Address: _____ City/State _____ Zip_____
Subscriber Name:_____ Employer:_____
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ____ / ____ / ____ Relationship to patient_____
ID#:_____ Group #:_____

Guarantor Information **(patients age 18 and under)**

Last Name:_____ First Name:_____ Middle:_____
Address:_____APT#_____
City_____ State:_____ Zip_____
Home Ph: (____) _____ Relationship to Patient:_____
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ / _____ / _____
Status: Single Married Widow Divorced Sex: Male Female Occupation:_____
Employer: _____ Employer Phone:(_____) _____

Consent/Release/Authorization

The insurance information listed on page one is current and correct. If any information is incorrect, I understand that I will be held responsible for any unpaid balance. I also understand and I agree that I will be responsible for any collection or legal fees associated with the collection of overdue balances that are my responsibility. It is my responsibility to notify Healthy Woman of any changes that occur in my insurance coverage.

I authorize Healthy Woman to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. In order to evaluate my present health status, I hereby consent, voluntarily, to undergo examination and necessary treatment by Healthy Woman. I authorize Healthy Woman to disclose my health information for treatment, payment and health care operations. I have read and understand the above and hereby, voluntarily give my consent and authorization.

Patient Signature_____ Date _____ / _____ / _____