Patient #:

Patient Registration and Update Form

Please Complete As Thoroughly as Possible

PLEASE PROVIDE YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE RECEPTIONIST.

PATIENT INFORMATION

SOCIAL SECURITY NUMBER:	FIRST NAME:	MI:	LAST NAME:	SUFFIX:
SEX:	DATE OF BIRTH:	MARITAL STATUS:	RACE:	
STUDENT STATUS: ☐ Part-time ☐ Full-time	EMPLOYMENT STATUS:	EMPLOYER:		
HOME ADDRESS LINE 1:				
HOME ADDRESS LINE 2:				
ZIPCODE:	CITY:	STATE:		
EMAIL:	HOME PHONE:	WORK PHONE:	EXTENSION: -	CELL PHONE:
REFERRAL SOURCE: ☐ Self ☐ Dr. ☐ Other:				

PRIMARY INSURANCE

INSURANCE COMPANY NAME:	PLAN C/S/Z:	
GROUP ID:	MEMBER ID:	COPAY: $
INSURED PARTY: ☐ Self ☐ Other	PATIENT'S RELATIONSHIP TO INSURED:	NAME OF INSURED:
INSURED SOCIAL SECURITY NUMBER:	INSURED DATE OF BIRTH:	INSURED EMPLOYER (REQUIRED):

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY NAME:	PLAN C/S/Z:	
GROUP ID:	MEMBER ID:	COPAY: $
INSURED PARTY: ☐ Self ☐ Other	PATIENT'S RELATIONSHIP TO INSURED:	NAME OF INSURED:
INSURED SOCIAL SECURITY NUMBER:	INSURED DATE OF BIRTH:	INSURED EMPLOYER (REQUIRED):

CONTACT INFORMATION

EMERGENCY CONTACT INDIVIDUAL:	EMERGENCY CONTACT TELEPHONE NUMBER:
EMERGENCY CONTACT WORK NUMBER:	RELATIONSHIP:
PREFERRED PHARMACY:	PHARMACY CITY/STATE:

Authorization to Release Information:

I hereby authorize Women's Health Associates, P.C. to release any information acquired during my examination or treatment to third-party payors for payment of all charges. Also, such information may be provided to recognized agencies for the purpose of accreditation, utilization, and peer review. Also, I have received a copy of the office NOTICE OF PRIVACY PRACTICES.

Authorization to Assign Benefits:

I hereby authorize payment to Women's Health Associates, P.C. of the surgical and/or medical benefits, if any, otherwise payable to me for their services. I understand that any payments received from the insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this release.

Acknowledgement of Charges and Responsibilities:

I hereby acknowledge my responsibility to pay any co-payments or deductibles not covered by my health insurance. I also accept that I am responsible to provide accurate and current insurance information so my insurance carrier can be billed correctly and in a timely fashion. I accept full financial responsibility for non-payment of my medical expenses by my insurance carrier resulting from my failure to provide accurate information. Also, I understand that a $20 charge will be imposed on my account for any returned check.

Signature: ______________________________ **Date:** ____________________