WOMEN'S CENTER FOR HEALTH
REGISTRATION FORM

PLEASE **PRINT** ALL INFORMATION **CLEARLY**

PATIENT INFORMATION

Legal Name_____ Date of Birth_____

(Maiden name/AKA/other name)_____

Street_____ Apt. #_____

City_____ State_____ Zip Code_____

Email _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____

Marital Status ☐ Married ☐ Single
☐ Widow/Widower
☐ Legally Separated

Race_____ Religion_____

Social Security #_____

Sex ☐ Male ☐ Female

Primary Care Physician_____

Patient's Mother's First Name_____

PATIENT'S EMPLOYER

☐ Student ☐ Child ☐ Retired

Employer's Name_____

Street_____

City_____ State_____ Zip Code_____

Patient Occupation_____

NEXT OF KIN (i.e. spouse, parent)

Name_____

☐ Same as patient

Street_____

Apt #_____

City_____

State_____ Zip Code_____

Home Phone_____

Work or Cell Phone (circle one)_____

Relationship to Patient_____

PERSON TO NOTIFY IN EMERGENCY

Name_____

☐ Same as patient

Street_____

Apt #_____

City_____

State_____ Zip Code_____

Home Phone_____

Work or Cell phone (circle one)_____

Relationship to Patient_____

PERSON FINANCIALLY RESPONSIBLE (GUARANTOR)

☐ Same as patient

Legal Name_____

Street_____Apt #_____

City_____State_____Zip Code_____

Home Phone_____ Work Phone_____ Relationship to Patient_____

***Social Security Number_____ Employer_____

INSURANCE INFORMATION

Primary Insurance Company_____

☐ Same as patient

Name of Policy Holder_____

ID#_____

Date of Birth_____

Effective Date_____

Home Phone_____

Work Phone_____

Relationship to Patient_____

Secondary Insurance Company_____

☐ Same as patient

Name of Policy Holder_____

ID#_____

Date of Birth_____

Effective Date_____

Home Phone_____

Work Phone_____

Relationship to Patient_____

How did you hear about the practice?_____

CONSENT FOR TREATMENT, RELEASE, ASSIGNMENTS, AND FINANCIAL AGREEMENT:

I hereby request and consent to the provision of healthcare services from the above physician members within his/her Women's Center for Health group practice and from non-physician healthcare professionals employed or otherwise retained within the practice. I authorize the practice to release any medical and other information in my medical or registration record to any entities or individuals having responsibility for authorization/payment for such healthcare services, for the purpose of determining eligibility and availability of health care benefits, and/or obtaining authorization/payment for such services. I agree that a copy of this authorization may be utilized as evidence of this authorization in place of the original. I further: i) agree to irrevocably assign and transfer to Women's Center for Health all right to medical reimbursement benefits to which I am entitled for the purpose of the payment of healthcare service charges ("Patient Charges"); ii) authorize payment of such benefits directly to Women's Center for Health; and iii) guarantee payment of, and agree to be fully responsible for, all Patient Charges to the extent that they are not satisfied by the assigned benefits.

-I acknowledge that if the correct insurance information is not given at the time of service a $15.00 rebill fee will apply.

-I understand that my account will be considered delinquent if payment is not received within 60 days and a statement fee of $15 per month will be charged.

_____ _____

Signature of Patient or Authorized Person & Relationship to Patient Date