THE WOMEN'S HEALTH GROUP, P.C.
PATIENT REGISTRATION

PATIENT INFORMATION

Legal Name_____
Last First Middle Initial

Street Address_____ Apt/Unit #_____

City_____ State_____ Zip Code_____

Birth Date_____ Age____ SS #_____ Marital Status / / S / / M / / D / / Other

Race _____ **Ethnicity** - Hispanic // Non-Hispanic // Decline

Home Phone_____ Work Phone_____

Mobile Phone_____ Email Address _____

Preferred Pharmacy_____ Address_____

Spouse/Responsible Party: Name_____ SS#_____

Work Phone_____ Employer/Occupation_____

INSURANCE INFORMATION

Primary Insurance_____ Type (HMO, PPO, etc)_____

Insured's Name_____ Relationship to Insured_____

ID #_____ Group #_____Insured's Birth Date_____

Claims Address_____

Membership Services Phone_____ **Effective Date**_____

Secondary Insurance_____ Type (HMO, PPO, etc)_____

Insured's Name_____ Relationship to Insured_____

ID #_____ Group #_____Insured's Birth Date_____

Claims Address_____

Membership Services Phone_____ **Effective Date**_____

ADDITIONAL INFORMATION

Emergency Contact_____ Relationship to patient_____
Home Phone_____ Work phone_____
Family Physician_____ Phone number_____

Whom may we thank for referring you? _____

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MEDICAL INFORMATION AUTHORIZATION: I authorize release of any medical information necessary to process my claims.

Signed_____ Date_____

ASSIGNMENT OF BENEFITS AND AGREEMENT FOR PAYMENT: I authorize medical benefits to the named provider. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all noncovered fees incurred within 30 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

Signed_____ Date_____