

CENTER for WOMEN'S HEALTH

PATIENT REGISTRATION & DISCLOSURE FORM

PLEASE PRINT

CHART # _____

Name: _____ Home Phone #: (____) _____
Last First M.I.

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

DOB: ____/____/____ Single Married Separated Divorced Widowed

Social Security #: _____-____-____ Driver's License #: _____ State: _____

Do you have a living will? Yes / No (circle one) Your Employer: _____

Work Address: _____ City, State & Zip: _____

Work Phone #: (____) _____ Cell Phone #: (____) _____

I may be contacted in the following manner(s):

Home Phone: Yes / No (circle one) Work Phone: Yes / No (circle one) Cell Phone: Yes / No (circle one)

Bills, lab reports, reminder cards, and other correspondence can be mailed to:

Home Address: Yes / No (circle one) Work Address: Yes / No (circle one)

Primary Care Physician: _____ Referred By: _____

Primary Insurance

Insurance Company: _____ ID# _____ Group# _____

Subscriber Name: _____ Social Security #: _____-____-____ DOB: ____/____/____

Relationship to you: _____ Subscriber Employer: _____

Subscriber Address: _____ City, State & Zip: _____

Subscriber Phone #: (____) _____

Secondary Insurance

Insurance Company: _____ ID# _____ Group# _____

Subscriber Name: _____ Relationship: _____ DOB: ____/____/____

Subscriber Address: _____ City, State & Zip: _____

Subscriber Phone #: (____) _____

Name of nearest relative **NOT** living with you: _____ Relationship to you: _____

Relative's Phone #: (____) _____

Alternative Contact Name: _____ Relationship to you: _____

Alternative Contact Phone#: (____) _____

Is it okay to leave a message with alternative contact: ____ Yes ____ No

I hereby authorize the practitioner to furnish to my Insurance Carrier all information necessary to process this claim. I authorize benefits under this claim to be made directly to the above practitioner. I am responsible financially for ALL charges not covered by this authorization. I am also financially responsible to the practitioner for charges and/or collection fees incurred if my account is referred to an outside agency or attorney for collection.

Responsible Party Signature

Relationship

____/____/____
Date