PATIENT REGISTRATION FORM

Account_____ Date_____

Patient Name_____
Last *First* *Middle* *Maiden*

DOB_____ Age_____ SS#_____ Marital Status S M D Separated

Permanent Address
(Not PO Box)_____
Street *City* *State* *Zip*

Mailing Address (if different)_____

Home Phone_____Cell Phone_____Work Phone_____

Pharmacy_____

Email Address_____

Place of Employment or School_____

Occupation_____

Family Physician_____ Referred by_____

Last Menstrual Period_____ Hysterectomy: Yes No Reason for Visit_____

Spouse Name_____ DOB_____ SS#_____

Spouse Place of Employment_____

Insurance Cardholder's Name_____DOB_____Employer_____

Emergency Contact Info (other than significant other)_____

Phone Number_____ Relationship to Patient_____

If a minor, please fill in responsible part information below:

Responsible Party_____ Relationship_____

Address if different from above

_____
_____

Place of Employment

_____
_____

Guarantor SS#_____

AUTHORIZATION TO TREAT MINOR

I authorize the physicians of Women First PC to treat and prescribe medications to:

_____ _____
Minor Child Relationship to Minor

_____ _____
Signature Date

Authorization SS# _____

Please present insurance card to receptionist

CONCERNING INSURANCE

I hereby authorize **Women First PC** to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the social security administration and health care financing administration.) A copy of this authorization may be used in place of the original. This authorization may be revoked by me or my insurance carrier at any time in writing.

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to **Women First PC** for services rendered. I further authorize the release of any information needed to process my insurance claims(s). A copy of this authorization may be used in place of the original.

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

FINANCIAL RESPONSIBILITIES

In the event my unpaid account must be turned over for collection, I understand I will be responsible to pay all reasonable costs including 40% of all collection fees and any attorney's fee(s).

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

LABORATORY FEES

Medicare, Medicaid, Blue Shield, and other certain insurance companies require you to be informed in advance that there may be certain laboratory procedures which may not be covered because the carrier may determine that the service is not "reasonable and/or necessary". It must be emphasized that in your physician's professional judgement these services are needed in order to render high quality medical care to you. However, in order for you to make an informed decision, you are advised that based on insurance guidelines, it is possible that your carrier may deny certain procedures.

By signing the statement, you are agreeing to pay for laboratory tests, even if your carrier determines that according to its guidelines the services are not "reasonable and/or necessary".

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*