Women's Health Consultants, PA
Patient Registration Form

Date:	Last Name:	First Name:	MI:	Preferred Name:
Date of Birth: Age:	SS#:	Race:	Primary Language:	
Country of Origin:	Pharmacy:	Employer:	Martial Status:	
Address:	City/State:	Zip:		
Home Phone:	Work Phone:	Cell Phone:	Primary Phone:	
Email:	Emergency Contact: Address: Phone:			
Responsible Party (If Not the Patient):	Relationship to Patient:	Referred By:		

Primary Insurance:	Secondary Insurance:
ID/Policy Number:	ID/Policy Number:
Group Number:	Group Number:
Effective Date:	Effective Date:
Policy Holder Information (If Different from Patient) Name: SS#: Date of Birth: Employer Name: Relationship to Patient:	Policy Holder Information (If Different from Patient) Name: SS#: Date of Birth: Employer Name: Relationship to Patient:

Release of Information

I request and authorize the release of all my medical information to referring, consulting or other treating physicians involved in my care.

Signature: _____ Date: _____

Assignment of Insurance Benefits

I consent to and authorize the payment of benefits for healthcare-related services to be made to Women's Health Consultants, P.A. This consent specifically authorizes Women's Health Consultants, P.A. to release protected healthcare information to insurers and governmental agencies and their agents for billing and determination of benefits purposes. Additionally, I assign any benefits payable for physician services to the physician or organization furnishing these services. I understand that I may be responsible for costs not covered by an insurer or third party payer.

Signature: _____ Date: _____