WOMEN'S HEALTH CONSULTANTS, PA
PATIENT REGISTRATION FORM

Date ___________________ Social Security Number ____

Patient Name ____ Age ______ Birth Date _____________
(last) (first) (middle)

How would you like us to address you? ____

Address ____

____ Home Phone ________________________
(city) (state) (zip code)

Employer ____ Cell Phone ________________________
(circle best daytime number)

Occupation/Title ____ Work Phone ________________________

Marital Status ______________________ Spouse's Name ____

Responsible party if other than patient ______________________________ Relation to patient ___________________

In the event of an emergency, whom can we contact other than a household member? ___________________________

Address ____ Telephone ________________________

Referred by ____

INSURANCE INFORMATION

Primary Insurance _________________________________

Insurance claims address __________________________

____
(city) (state) (zip code)

Insurance phone _________________________________

Policy number ___________________________________

Group number ___________________________________

Effective date ___________________________________

Policyholder Information (if different from patient)

____
(name)

____
(Social Security No.) (Date of birth)

____
(Employer name)

____
(Relationship to patient)

Secondary Insurance _________________________________

Insurance claims address ______________________________

____
(city) (state) (zip code)

Insurance phone _____________________________________

Policyholder Information _______________________________
(name)

____
(Social Security No.) (Date of birth)

____
(Employer name)

____
(Relationship to patient)

RELEASE OF INFORMATION

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

Signature ____ Date ____________________

ASSIGNMENT OF INSURANCE BENEFITS

I consent to and authorize that payment of benefits for healthcare-related services be made to Women's Health Consultants, PA. This consent specifically authorizes Women's Health Consultants, PA, 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 ________________________________