Dedicated to Women ObGyn

Patient Registration

Pharmacy: _____ Pharmacy location: _____

Patient Account # _____ Date _____

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

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

Primary Phone: _____ Home Cell Work Secondary Phone: _____ Home Cell Work

Email Address: _____

Marital Status: Single Married Widowed Divorced Social Security #: _____

Have you ever been a patient at our practice? Yes No If yes, under what name: _____ When? _____

Referring Physician: _____ Family Physician: _____

Patient's Employer: _____

Spouse's Name: _____ Spouse's Employer: _____ Work Phone: _____

PRIMARY MEDICAL INSURANCE

Insurance Company: _____ Effective Date: _____

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

Subscriber's Name: _____ Subscriber's Date of Birth: _____ Subscriber's ID#: _____

Group or Account# _____ Subscriber's Employer _____

Subscriber's Social Security #: _____ Medicare #: _____ Medicaid #: _____

SECONDARY MEDICAL INSURANCE

Insurance Company: _____ Effective Date: _____

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

Subscriber's Name: _____ Subscriber's Date of Birth: _____ Subscriber's ID#: _____

Group or Account#: _____ Subscriber's Employer: _____

Subscriber's Social Security # :_____ Medicare #: _____ Medicaid #: _____

USE AND DISCLOSURE

In addition to phone calls to your primary number, how may we best contact you? Please check all that apply:

Appointment Reminders Email Text Message

Confidential Messages Primary Number Secondary Number Email

Please list a contact who we may inform about your general medical condition, diagnosis and/or appointment information:

Name: _____ Phone #: _____ Relationship: _____

Please list an Emergency contact:

Name: _____ Phone #: _____ Relationship: _____

Please list a contact, if any, whom we may discuss your account and billing with:

Name: _____ Phone #: _____ Relationship: _____

I have been offered a copy of the Dedicated to Women OB-GYN Privacy Notice: Yes No I have declined a copy: Yes No

I authorize release of any medical information necessary to process my claims and request payment of insurance benefits be paid directly to Dedicated to Women, OB-GYN, PA. I also authorize releases of medical information necessary to process disability, loss of income, or any other forms requested by me or my insurance company on my behalf. I further authorize the release of above requested information via FAX and/or electronic transmission.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE.
In the event that any account is placed with a third party for collection, I agree to pay the collection agency fee of 35% in addition to the balance owed on the account.

Patient Signature: _____ Date: _____