

WELCOME TO OUR PRACTICE

WOMEN'S CARE  
MEDICAL GROUP



(Business Office Use)

Acct # \_\_\_\_\_

Chart # \_\_\_\_\_

**PATIENT REGISTRATION**

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Bus. # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

If full time student, name of school \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Drivers License \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Primary Physician \_\_\_\_\_

Cell # \_\_\_\_\_

Employed by \_\_\_\_\_

Marital Status: single: \_\_\_\_\_ married: \_\_\_\_\_ widowed: \_\_\_\_\_ separated: \_\_\_\_\_ divorced: \_\_\_\_\_

Spouse/Next of Kin \_\_\_\_\_ Relationship \_\_\_\_\_

Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

In case of Emergency, who should be notified \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Please complete all items very carefully. Any future change in insurance information, please let us know as soon as possible. If you have more than one health insurance, to receive maximum benefits, please supply all information for both policies. **Failure to supply proper insurance information may result in your claim being denied, therefore you will be billed the full balance.** This information will be strictly kept confidential in our office. (Lines with \*\* must be filled in)

**PRIMARY INSURANCE**

Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Parent: \_\_\_\_\_ Other: \_\_\_\_\_

Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ **\*\* Relationship** \_\_\_\_\_

**\*\* Date of Birth** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

**SECONDARY INSURANCE**

Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Parent: \_\_\_\_\_ Other: \_\_\_\_\_

Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ **\*\* Relationship** \_\_\_\_\_

**\*\* Date of Birth** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

**Co-pay is due at time of service.** If we are not a provider of your insurance company or if you have no insurance, we request payment in full at time of service. We do not customarily bill secondary for co-pay. As a courtesy we will bill your insurance claim for you. **If your insurance does not pay within 90 days you will be responsible to make payments upon receipt of statement.**

I authorize my insurance benefits to be paid directly to my physician. I am financially responsible for non-covered services and understand that regardless of insurance coverage, I am ultimately responsible for payment of all medical charges incurred. I authorize this office to obtain necessary records, lab, ultrasound or x-ray results via phone or fax. I also authorize this office to furnish pertinent medical information to insurance carriers to process any claims.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_