PATIENT REGISTRATION FORM

LAST NAME _____ **FIRST** _____ **M. I.** _____ **MAIDEN** _____

ADDRESS _____ **PRIM. CARE PHYS** _____

CITY, STATE, ZIP CODE _____

HOME PHONE _____ **WORK PHONE** _____ **CELL PHONE** _____

E-MAIL ADDRESS _____

_____ Yes, you can confirm my appointment by e-mail
_____ Yes, you can send my test result by e-mail
_____ Yes, all communication may be made through e-mail

OCCUPATION _____ **EMPLOYER** _____

DATE OF BIRTH _____ **SOCIAL SECURITY** _____ **MARITAL STATUS** _____

SPOUSE'S NAME _____ **SPOUSE'S OCCUPATION** _____

SPOUSE'S EMPLOYER _____ **SPOUSE'S WORK PHONE** _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____ PHONE _____

RELATIONSHIP TO YOU: _____ PARENT _____ SPOUSE _____ SIBLING _____ FRIEND _____ OTHER

GUARANTOR (PARTY INSURANCE IS UNDER)

RELATIONSHIP TO PATIENT _____

_____ I AM THE INSURED/GUARANTOR

NAME _____ DATE OF BIRTH _____ SSN# _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ WORK PHONE _____ EMPLOYER _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

INSURED _____ INSURED _____

INSURED DATE OF BIRTH _____ INSURED DATE OF BIRTH _____

INSURED SSN: _____ INSURED SSN: _____

INSURANCE ID NUMBER _____ INSURANCE ID NUMBER _____

GROUP NUMBER _____ GROUP NUMBER _____

AUTHORIZATION AND CONSENT

I, THE UNDERSIGNED, ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL BILLS INCURRED WHILE RECEIVING SERVICES FROM WOMEN'S CARE CONSULTANTS, LLC. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I FURTHER AUTHORIZE THE ACCESS OF HISTORICAL PRESCRIPTION DRUG INFORMATION FROM OUTSIDE SOURCES. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

PATIENT SIGNATURE **DATE**