ASSOCIATES IN GYNECOLOGY

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name ____________________ SS# ____________________

Birth Date ____________________ Sex: ___Male ___Female

Permanent Address ____________________

City ____________________ State ____________________ Zip ____________________

Home Phone ____________________ Email Address ____________________

Work Phone ____________________ Cell Phone ____________________

Guarantor Name ____________________ Guarantor Address ____________________

Guarantor Phone ____________________

Patient Employer ____________________ Employer Address ____________________

City ____________________ State ______ Zip ______ Phone ______

Referring Doctor ____________________ Phone ____________________

Primary Care Physician ____________________ Phone ____________________

Who may we thank for referring you to our practice: ____________________

Marital Status ___Single ___Married ___Divorced ___Widowed ___Separated

Employment ___FT ___PT ___Not Emp ___Self Emp ___Retired ___Student

INSURANCE INFORMATION

Primary Insurance Carrier ____________________

Subscribers Name ____________________ Subscriber Birthdate ____________________

Relationship of Subscriber to Patient ____ Self ____Spouse ____Child ____Other

Secondary Insurance Carrier ____________________

Subscribers Name ____________________ Subscriber Birthdate ____________________

Relationship of Subscriber to Patient ____ Self ____Spouse ____Child ____Other

Insurance claims will be filed on your behalf with correct insurance information

I hereby consent for Associates In Gynecology to provide me with medical treatment. I authorize the release of medical information contained in my chart to my, or the insured's insurance company, in order to process any bills. I authorize the use and disclosure of my private health information for the purpose of : Treatment, Payment and Healthcare Operations. I authorize payment from my, or the insured's insurance company directly to Associates in Gynecology. Should my insurance company deny or not cover charges for ANY reason, I am financially responsible for the full amount of the bill.

Should my account be referred to an outside collection agency, I agree to pay the collection fees.

____________________ ____________________

Signature of Patient (or Parent if Minor) Date