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