PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last)*_____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Address _____

Phone Number _____ Social Security # _____ Driver's License #_____

Employer _____ Phone _____

Employer Address _____

Referring Physician _____

If Student, School Name _____ Full-Time / Part-Time

Responsible Party

Name _____ Relationship to Patient _____

Address_____

Phone Number _____ Social Security # _____

Employer _____ Phone Number _____

Employer Address_____

Emergency Contact _____ Phone Number _____

Insurance Information

Insurance Company _____ Phone Number _____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Employer Address_____

Insured's Social Security # _____ Date of Birth _____ Male / Female

I hereby assign, transfer, and set over to Preferred Gynecology all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____