COMPREHENSIVE
WOMEN'S HEALTH

Comprehensive Women's Health Patient Registration

First Name:_____ MI:_____

Last Name:_____

SSN.:_____ **DOB**:____/____/_____

Sex: F / M **Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

☐ Employed ☐ Student ☐ Other_____

Employer/School:_____ _____

_____

Work Phone: _____

Home Address:_____

_____

City:_____**State**:_____**Zip**:_____

E-Mail:_____

Preferred number to call:↑ Home ↑/ Work / ↑Cell

Home Phone: _____

Cell Phone: _____

Primary Insurance Information (Please provide your insurance card to the receptionist)

☐ Commercial ☐ Medicare Insurance Company: _____

Insured/Card Holder's Name:_____ Relationship:_____

DOB: _____ Policy No.:_____ Group No.:_____ Phone: _____

Secondary Insurance Information (Please provide your insurance card to the receptionist)

☐ Commercial ☐ Medicare Insurance Company: _____

Insured/Card Holder's Name:_____ Relationship:_____

DOB: _____ Policy No.:_____ Group No.:_____ Phone: _____

Emergency Contact Information

Full Name:_____ Relationship:_____

Home Phone:_____ Work Phone:_____

Guarantor/Responsible Party

First Name:_____ MI:_____ Last Name:_____

SSN:_____ DOB: _____/_____/_____ Home Phone: _____

Home Address:_____ City:_____State:_____Zip:_____

FINANCIAL POLICY: I hereby authorize payment directly to the Physician of the Medical and/or Surgical benefits, if any, otherwise payable to me for his/her services as described. I certify that the information I have reported is correct. I acknowledge that it is the policy of this office to collect any co-payments or deductibles at the time of each visit. I am also responsible to notify the office on any change in my insurance prior to my visit. If I have an HMO plan, I will select my PCP prior to my office visit. I understand that I am financially responsible for services that are not covered by my health insurance, or if payment is denied. I agree that in the event I do not pay for services provided, I will pay for the cost of collection, and/or court costs and reasonable attorney fees should this be required. I understand that in the absence of a payment plan, outstanding balances may accrue 1.5% interest per month after 30 days.

CONFIDENTIALITY: As your physician, it is necessary to communicate in writing, by phone, fax or electronic communication to other health care providers, health insurance companies, Medicare/Medicaid or health claims clearinghouses. Communication between your doctors is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information about you be sent to them and you have agreed to release this information as a participating member. The practice will make its best efforts to protect your privacy. This includes nondisclosure of your personal health information for marketing and fundraising purposes. I acknowledge that I have had an opportunity to read the office's Notice of Privacy Practices that contains a description of the uses and disclosures of my personal health information. The policy of this office is to strive to be in compliance with federal and state medical practice guidelines.

Patient Signature _____ Date _____