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Obstetrics and Gynecology
A Professional Medical Corporation

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PATIENT REGISTRATION
(PLEASE PRINT & FILL OUT COMPLETELY)

Patient's Name_____SS#_____ Date of Birth _____

Mailing Address_____ Primary Phone_____

City, State, Zip _____ Secondary Phone _____

Employer_____ Work Phone _____

Race _____ Ethnicity _____ Language_____ Religion _____

E-Mail _____ (Married) (Single) (Widowed) (Divorced) (Legally Separated) (Partner)

Spouse's Name _____ Spouse's SS#_____

Spouse's Date of Birth _____ Spouse's Employer & Phone #_____

PLEASE UNDERSTAND THAT WE WILL BE HAPPY TO FILE YOUR MEDICAL CLAIM(S) FOR YOU PROVIDED THAT IT'S A COMPANY WE ARE CONTRACTED WITH. WE ALSO ASK YOU TO **GIVE US YOUR MOST CURRENT INSURANCE CARD EACH TIME YOU VISIT OUR OFFICE.** IT IS IMPORATANT FOR YOU TO UNDERSTAND THAT THIS IS A CONTRACT BETWEEN YOU AND THE INSURANCE COMPANY THAT YOU HAVE CHOSEN TO COVER YOU/YOUR FAMILY.

IF THERE IS ANY BALANCE DUE TO THE PHYSICIAN, I AUTHORIZE MY INSURANCE COMPANY TO PAY THE PHYSICIAN DIRECTLY. IF FOR ANY REASON (ie: failure to obtain referral, coverage terminating, etc.) MY INSURANCE COMPANY FAILS TO REIMBURSE THE DOCTOR(S) THE CONTRACTED AMOUNT, I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY FOR SERVICES RENDERED AND/OR PURSUE THE UNPAID AMOUNT WITH MY INSURANCE COMPANY. MY SIGNATURE WILL ALSO AUTHORIZE RELEASE OF MEDICAL INFORMATION REQUESTED BY MY INSURANCE CARRIER AND VERIFY THAT I HAVE RECEIVED THE MOST CURRENT COPY OF THE OFFICE'S PRIVACY POLICY.

SIGNATURE: _____ DATE: _____

(INSURANCE INFORMATION MUST BE FILLED OUT COMPLETELY AND INSURANCE CARD PRESENT TO FILE)

Primary

Insurance Company _____ Claim Address _____

ID# _____ Group #_____

If group policy, is coverage through you, spouse, or parents? _____

What is the name, DOB and relation to the patient the coverage is under? _____

Who is the employer that carries the group policy? _____

Secondary (if applicable)

Insurance Company _____ Claim Address _____

ID# _____ Group #_____

If group policy, is coverage through you, spouse, or parents? _____

What is the name, DOB and relation to the patient the coverage is under? _____

Who is the employer that carries the group policy? _____