



PATIENT REGISTRATION FORM

Date: _____

Patient's Full Name (Please print): _____
Last First MI Maiden Name

Address: _____
P.O. Street City State Zip

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ E-Mail Address: _____
Month Day Year

Social Security No: _____ Marital Status: S M W D Sep

Patient's Employer: _____
Name Telephone Number

Occupation (Indicate if Student): _____

Spouse or Parent's Name: _____ Social Security No: _____ Date of Birth _____
(if minor)

Spouse or Parent's Address: _____
P.O. Street City State Zip

Spouse or Parent's Employer: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

REFERRAL INFORMATION (Please tell us who referred you to our practice)

Family Physician, Health Plan, or Other: _____

HOW DID YOU HEAR ABOUT US: (Circle all that apply) Friend Family Radio TV Newspaper Yellow Pages

INSURANCE INFORMATION Do you have insurance? Yes No

(Please show the receptionist your insurance card(s) so that we may make copies of them)

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient or guarantor. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient or guarantor is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with the business office.

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to Ob-Gyn Specialists, P.C. for any services furnished me by that party who accepts assignment/clinician regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare clam/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information). 11/2002

Signature: _____ Date: _____