Patient Registration Form 2015

PLEASE PRINT, fill out all of the fields and bring with you to your appointment

Patient Information

Social Security Number: ________________________

Last Name: ____________________________________

First Name: _____________________ MI: ____ Jr Sr

Preferred/Nickname: ___________________________

Address: ______________________________________

____

City: ______________ State: ______ Zip: __________

Preferred Language: ____________________________

Marital Status: □ Never Married □ Married □ Annulled

□ Divorced □ Widowed □ Separated □ Partnered

Spouse/Partner Name: __________________________

Date of Birth: ____________________________

Home Telephone Number (____) _____-______

Work Telephone Number (____) _____-______

Cell Telephone Number (____) _____-______

Gender: □ Female □ Male

Race: □ White □ Black/African American □ Asian

□ American Indian/Alaskan Native □ Hispanic

□ Native Hawaiian/Pacific Islander □ Other

Ethnicity: □ Hispanic or Latino □ Other

Are you pregnant? □Yes □No

Email: ____ May we e-mail personal information to you? □ Yes □ No

** Email may be used to send you information about your appointments and other information about our clinical practices. **

Student Status: □ None □ Part-Time □ Full-Time

School: __________________________________

Employed: □ Employed □ Unemployed □ Retired □ Leave of Absence □ Disabled □ Homemaker

Employer Name: ____ Position: ______________________________________

••

Contact Information

Emergency Contact:

Name: ___________________________________ Telephone Number (____) _____-______

Address: ____ Relationship: _______________________

Primary Caregiver (if applicable)

Name: ___________________________________ Telephone Number (____) _____-______

Address: ____ Relationship: _______________________

Legal Guardian (if applicable)

Name: ___________________________________ Telephone Number (____) _____-______

Address: ____ Relationship: _______________________

Healthcare Proxy (if applicable)

Name: ___________________________________ Telephone Number (____) _____-______

Address: ____ Relationship: _______________________

••

How did you hear of our office? ____

* example: physician referral, family member, newspaper, magazine, television, radio, internet, other.

If physician referral, what is their name? ____

Who is your PCP? ___________________________________ Telephone Number (____) ______-______

Preferred Pharmacy__________________________________ Telephone Number (____) ______-______

** For your protection, and in compliance with Federal Regulatory Requirements to safeguard against identity theft, you will be required to provide us with a valid photo ID with your current address and your insurance card every visit. A copy will be kept on file in order to verify your identity in respect to any requests for your medical information and submitting of information to your insurance carrier for payment. Thank you.

(Please Complete Back of Form)

Account Information

Is the above referenced patient over the age of 18? □ Yes □ No

If yes, the patient is legally responsible for all financial obligations to this office.

If No, list the person who is financially responsible for this account; this should be the person that is bringing the minor to doctor's appointments.

Last Name: _____ Date of Birth: _____

First Name: _____ MI: _____ Jr Sr Home Telephone Number (____) _____-_____

Address: _____ Work Telephone Number (____) _____-_____

_____ Cell Telephone Number (____) _____-_____

City: _____ State: _____ Zip: _____ Social Security Number: _____

Employer: _____ Relationship to the patient: _____

Insurance information: Please be prepared to give your insurance card(s) to the receptionist. This will be scanned into our system to enable us to submit claims to your insurance company on your behalf.

PRIMARY INSURANCE COMPANY: _____ Effective Date:_____

SUBSCRIBER *If the patient is not the policy holder, please list the policy holder's information below.*

Last Name: _____ Home Telephone Number (____) _____-_____

First Name: _____ MI: ____ Jr Sr Cell Telephone Number (____) _____-_____

Address: _____ Birthdate:_____ SS#:_____

_____ Relationship to Insured: □ Self

City: _____ State: _____ Zip: _____ □ Spouse

ID or Policy #: _____ □ Child

Group#: _____ □ Other: _____

Name of Employer: _____

SECONDARY INSURANCE COMPANY: _____ Effective Date: _____

SUBSCRIBER *If the patient is not the policy holder, please list the policy holder's information below.*

Last Name: _____ Home Telephone Number (____) _____-_____

First Name: _____ MI: ____ Jr Sr Cell Telephone Number (____) _____-_____

Address: _____ Birthdate:_____ SS#:_____

_____ Relationship to Insured: □ Self

City: _____ State: _____ Zip: _____ □ Spouse

ID or Policy #: _____ □ Child

Group#: _____ □ Other: _____

Name of Employer: _____

TERTIARY INSURANCE COMPANY: _____ Effective Date: _____

SUBSCRIBER *If the patient is not the policy holder, please list the policy holder's information below.*

Last Name: _____ Home Telephone Number (____) _____-_____

First Name: _____ MI: ____ Jr Sr Cell Telephone Number (____) _____-_____

Address: _____ Birthdate:_____ SS#:_____

_____ Relationship to Insured: □ Self

City: _____ State: _____ Zip: _____ □ Spouse

ID or Policy #: _____ □ Child

Group#: _____ □ Other: _____

Name of Employer: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS, AND REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS OR PARTICIPATES IN MY INSURANCE PLAN.

SIGNED:_____ DATE: _____

I UNDERSTAND THE PROVIDER'S CHARGES MAY EXCEED THE INSURANCE PAYMENTS, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT. SHOULD MY ACCOUNT EVER BECOME DELINQUENT AND ELIGIBLE FOR COLLECTION, I UNDERSTAND AN APPROPRIATE COLLECTION FEE WILL BE ASSESSED.

SIGNED:_____ DATE: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA) 2015

I acknowledge that I have received and understand Women's Wellness & Gynecology *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Women's Wellness & Gynecology may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Women's Wellness & Gynecology *Notice of Privacy Practices* by submitting a request in writing for a current copy of Women's Wellness & Gynecology *Notice of Privacy Practices.*

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (please initial all that apply)

_____Home Telephone Answering Machine:
_____OK to leave msg with detailed information
_____Leave msg with call back number ONLY

_____Written Communication:
_____OK to mail to my home address
_____OK to fax to this number:_____*

__ Cell Phone: _____*

__Email:_____*

_____Work Telephone:
_____OK to leave detailed message
_____Leave msg with call back number ONLY

_____Release to Immediate Family:
_____OK to leave detailed information
_____Leave msg with call back number ONLY

_____Initial to provide consent for review of Pharmaceutical/Medication/Prescription History electronically

It is your responsibility as the patient to communicate to our office with written notification of changes in cellphone or email contact

---

Release of Information Authorization

I hereby authorize Women's Wellness & Gynecology or any agent of to release the following medical information:

__ Blood work results __ Diagnostic Test Results __Consultant/Procedure Results __Medical Questions

The above items may be released to the following person(s):

Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____

For Women's Wellness & Gynecology Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative:

Women's Wellness & Gynecology made a good faith effort to obtain patient's written acknowledgment of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

□ Patient or patient's personal representative refused to sign.
□ Patient or patient's personal representative unable to sign.
□ Other: _____

_____	_____	_____
Printed Employee Name	Employee Signature	Date