WOMEN'S HEALTH CENTER
PATIENT REGISTRATION FORM
PLEASE COMPLETE ENTIRELY

SOC SEC #_____ US CITIZEN? ☐ yes ☐ no

PATIENT NAME_____
(LAST) (FIRST) (MI) (BIRTHDATE)

STREET & PO BOX #_____CITY,STATE,ZIP_____

HOME PHONE_____WORK PHONE_____EXT_____CELL PHONE_____

☐ **MARRIED** ☐ **DIVORCED** ☐ **SINGLE** ☐ **WIDOWED**

EMPLOYER NAME_____ OCCUPATION_____

EMPLOYER ADDRESS_____ CITY,STATE,ZIP_____

SPOUSE ***OR*** SIGNIFICANT OTHER ***OR*** PARENT INFORMATION* (*If parent information, fill both name sections completely)

NAME_____ *NAME_____

ADDRESS_____ *ADDRESS_____

CITY,STATE,ZIP_____ *CITY,STATE,ZIP_____

HM PH_____ WK PH_____ *HM PH_____WK PH_____

SOC SEC#_____ BIRTH DATE_____ *SOC SEC#_____ BIRTH DATE_____

EMPLOYER_____ *EMPLOYER_____

EMPL ADD_____ *EMPL ADD_____

PHARMACY NAME _____ LOCATION _____

FAMILY DOCTOR NAME_____ADDRESS_____PHONE#_____

PRIMARY INSURANCE INFORMATION ***SECONDARY INSURANCE INFORMATION***

INSURANCE NAME_____ INSURANCE NAME_____

EFFECTIVE DATE_____GROUP#_____ EFFECTIVE DATE_____GROUP#_____

POLICY HOLDER NAME_____ POLICY HOLDER NAME_____

POLICY HOLDER BIRTHDATE_____ POLICY HOLDER BIRTHDATE_____

POLICY HOLDER ID#_____ POLICY HOLDER ID#_____

ASSIGNMENT OF BENEFITS: I/patient hereby authorize my signature on all insurance and Medicare claim forms at the office of Women's Health Center for payment directly to Dr. Mark F. Morrison or to Dr. Paul W. Morrison for services rendered to me/patient. I authorize this office to release all information with respect to myself or any of my dependents which is necessary or required for the processing of claims under said insurance policy. I/patient understand that I am personally responsible for charges incurred whether my insurance pays or not. I/patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services I/patient received. I agree that this statement applies to all current and future claims.

SIGNATURE_____DATE_____

PLEASE DO NOT MAIL – BRING WITH YOU TO YOUR APPOINTMENT ALONG WITH YOUR INSURANCE CARD(S)

(OVER)

I UNDERSTAND IT MAY BE NECESSARY TO DISCUSS MY MEDICAL INFORMATION WITH PERSONS LISTED BELOW. I AUTHORIZE THE FOLLOWING PERSONS MAY BE CONTACTED ON MY BEHALF.

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

SIGNATURE OF PATIENT/GUARDIAN DATE

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY RIGHTS AND PRACTICES AND HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THAT NOTICE.

SIGNATURE OF PATIENT/GUARDIAN DATE