Women's Health Associates Group

PATIENT REGISTRATION

(Please Print and Complete All Entries)

PATIENT

PATIENT NAME (LAST, FIRST, MIDDLE)			MAIDEN NAME / ALIAS	SOCIAL SECURITY NUMBER
DATE OF BIRTH	AGE	SEX	MARITAL STATUS: Married Single Divorced Widowed	RACE: Native American Hispanic Caucasian African American Asian Other_____
ADDRESS			CITY, STATE	ZIP CODE
TELEPHONE (PRIMARY		CELL PHONE / PAGER	PRIMARY CARE PHYSICIAN	PHYSICIAN'S TELEPHONE
EMPLOYER		EMPLOYER ADDRESS	CITY, STATE	ZIP CODE
EMPLOYER TELEPHONE	EXTENSION	OCCUPATION		PATIENT'S EMAIL

GUARANTOR

GUARANTOR	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX
ADDRESS	CITY, STATE		ZIP CODE		
EMPLOYER	OCCUPATION	EMPLOYER TELEPHONE	CELL PHONE / PAGER		

PRIMARY EMERGENCY CONTACT		SECONDARY EMERGENCY CONTACT	
NAME	RELATIONSHIP TO PATIENT	NAME	RELATIONSHIP TO PATIENT
TELEPHONE (PRIMARY)	TELEPHONE (SECONDARY)	TELEPHONE (PRIMARY)	TELEPHONE (SECONDARY)
Women's Health Associates Group may communicate with this person regarding: Emergency only Appointments Test Results Financial Account Prescriptions All Information Other: _____		Women's Health Associates Group may communicate with this person regarding: Emergency only Appointments Test Results Financial Account Prescriptions All Information Other: _____	

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURED NAME	INSURANCE COMPANY NAME	INSURED NAME	INSURANCE COMPANY NAME
BILLING ADDRESS		BILLING ADDRESS	
CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE
TELEPHONE	EFFECTIVE DATE	TELEPHONE	EFFECTIVE DATE
INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH
GROUP NUMBER	POLICY NUMBER	GROUP NUMBER	POLICY NUMBER

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES – A detail of your rights and how your medical information will be used and disclosed by Women's Health Associates Group, LLC is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been furnished to me and is posted in the clinic.

I understand and agree that I am financially responsible for the balance on my account for all professional services rendered. I also understand that, Women's Health Associates Group, LLC will submit charges to my insurance carrier. If I do not have insurance coverage, I will be responsible for payment in full at the time of service. I understand that if my account is delinquent, I am responsible for any interest fees and collection fees associated with my outstanding delinquent balance.

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF GUARDIAN	DATE