

Women's Health Center

PATIENT REGISTRATION FORM

Physician to be seen at this visit: _____

Patient Information

Name: _____, _____ DOB: ____/____/____
Last First

Address: _____ Home Phone: () ____/____/____
City: _____ Zip Code: _____ Work Phone: () ____/____/____
SSN: ____-____-____ Cell Phone: () ____/____/____
Marital Status: Single [] Married: [] Divorced: [] Other: []
Emergency Contact: _____ Phone: _____
Referring Physician: _____

Patient Insurance Information (PRIMARY)

Company Name: _____ Name of Policy Holder: _____
Address: _____ SSN: ____/____/____
City: _____ State: _____ Birthdate: ____/____/____ M [] F []
Policy # _____ Group# _____ Employer: _____
Relationship of Patient to Insured: Self [] Spouse [] Child [] Other [] Explain:

Patient Insurance Information (SECONDARY)

Company Name: _____ Name of Policy Holder: _____
Address: _____ SSN: ____/____/____
City: _____ State: _____ Birthdate: ____/____/____ M [] F []
Policy# _____ Group# _____ Employer: _____
Relationship of Patient to Insured: Self [] Spouse [] Child [] Other [] Explain:

Billing Information: Amount not paid by the insurance company should be sent to the following person:

Name: _____ Employer: _____
Address: _____ Employer Phone#: () ____-____
City: _____ State: _____ Employer Address: _____
Zip Code: _____ Phone#: () ____-____
Birthdate: ____-____-____ SSN: ____-____-____

CONSENT TO TREAT & AUTHORIZATION FOR RELEASE OF BILLING INFORMATION: Please read completely and sign. Services may be withheld if not signed. I recognize the need for health care and consent to services as ordered by the physician (s). I hereby authorize the release of any medical information necessary from Wright State Physicians, Inc. for insurance claim submission and/or payment for services. I authorize payment of medical payment to Wright State Physicians, Inc., for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

I have read the above statement and understand my financial responsibilities.

SIGNATURE OF PATIENT: _____ Date: _____

PARENT OR GUARDIAN IF MINOR: _____ Date: _____