



PATIENT REGISTRATION FORM

Reason for visit: _____

Physician to be seen at this visit: _____

Patient Information

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

Address: _____ Home #: () ____ - ____

City: _____ Zip Code: _____ Work #: () ____ - ____

SSN: ____ - ____ - ____ Email Address: _____ Cell #: () ____ - ____

Marital Status: _____ Single _____ Married _____ Divorced _____ Other

Emergency Contact: _____ Phone: _____

Referring Physician Name: _____

How did you hear about us? _____ Newspaper _____ Website _____ Health Fair/Event (which one?) _____

_____ Other _____ Friend/Patient (if a patient, please include their name as we'd like to thank them) _____

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: _____ Spouse _____ Parent _____ Child _____ Self _____ 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: _____ Spouse _____ Parent _____ Child _____ Self _____ Other (explain) _____

Consent to Treat & Authorization for Release of Billing Information

Please read the following completely and sign below where indicated. 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 Women's Health Care (WSP WHC) for insurance claim submission and/or payment for services. I authorize payment of medical benefits to WSP WHC for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for procedures and services rendered, and/or any related fees.

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

SIGNATURE OF PATIENT: _____ **Date:** _____

PARENT OR GUARDIAN, IF MINOR: _____ **Date:** _____