ADVANCED WOMEN'S OBGYN ASSOCIATES PATIENT REGISTRATION FORM

Patient name: (Last)_____ **(First)**_____ **(Middle)** _____

Birth date: _____ **SSN#:** _____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Email address: _____ **Do you have an Advance Directive (e.g., living will)?** ☐ Yes ☐ No

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Languages spoken:** ☐ English ☐ Spanish ☐ Chinese ☐ Other: _____

Race: ☐ White ☐ Black/African Amer ☐ Amer Indian/Alaskan Native ☐ Native Hawaiian ☐ Asian ☐ Other: _____

Phone number: Home _____ Cell _____ Work _____

Best method of contact during day: ☐ Home ☐ Cell ☐ Work

Address: _____

Employment status: ☐ Employed ☐ Full-time student ☐ Part-time student ☐ Retired ☐ Self-employed ☐ Unemployed ☐ Homemaker

Employer: _____ Occupation: _____

Emergency contact: _____ Relationship: _____ Phone number:_____

Who is your primary care physician? _____ Phone number:_____

RESPONSIBLE PARTY INFORMATION: If patient is Responsible Party, please check here and skip to next section ☐

Responsible party name: (Last)_____ (First)_____ (Middle) _____

Social Security Number: _____ Birth date: _____ Patient relationship: _____

Phone number: Home _____ Cell _____ Work _____

Address: _____

PRIMARY INSURANCE INFORMATION: If patient has no insurance, please check here and skip to bottom of page ☐

Name of insured: _____ Patient relationship to insured: _____

Insured date of birth: _____ Insured Social Security Number: _____

Insurance company:_____ Subscriber ID (Policy number): _____ Group ID_____

SECONDARY INSURANCE INFORMATION: If patient has no secondary insurance, please check here and skip to bottom of page ☐

Name of insured: _____ Patient relationship to insured: _____

Insured date of birth: _____ Insured Social Security Number: _____

Insurance company:_____ Subscriber ID (Policy number): _____ Group ID_____

PLEASE HAVE INSURANCE CARDS AND PHOTO ID AVAILABLE AT CHECK IN

I AGREE THAT THE INFORMATION SUPPLIED ON THIS FORM IS ACCURATE AND UP-TO-DATE. I UNDERSTAND THAT I AM RESPONSIBLE FOR UPDATING THE ABOVE INFORMATION AS SOON AS IT CHANGES. THIS ALLOWS NOT ONLY ACCURATE BILLING BUT ALSO TIMELY NOTIFICATION OF MEDICAL RESULTS OR TREATMENTS.

My signature below verifies my receipt of the Patient Rights and Responsibilities notice.

ASSIGNMENT OF INSURANCE: I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Advanced Women's OBGYN Associates for services rendered by any of its employees. I further authorize the release of any medical information required by my insurance carrier.

Patient (or Guardian) Signature:_____ Date: _____