PATIENT REGISTRATION FORM -

MEDICAL RECORD #: ______________
(Office Use Only)

FIRSTNAME: _________________ MI: _______

LASTNAME: ____________________________

DOB: ____________ SS#: ________________

AGE: _______ RACE (optional): ____________

ADDRESS: ____________________________

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____________________ _____ __________
CITY STATE ZIP

CONTACT PHONE: ______________________

WORK PHONE: _________________________

CELL PHONE: _________________________
PATID2

EMAIL: ______________________________

OCCUPATION: ___________________________

EMPLOYER / SCHOOL: ___________________

EMERGENCY CONTACT:

NAME: _________________________________

PHONE NUMBER: _______________________

IS IT OK TO LEAVE PERSONAL AND / OR CONFIDENTIAL INFO ON YOUR HOME ANSWERING MACHINE SYSTEM?
[ ] YES [ ] NO

IS IT OK TO DISCUSS MEDICAL ISSUES WITH YOU AT YOUR WORK NUMBER?
[ ] YES [ ] NO

HOW DID YOU HEAR ABOUT US?: _______________

REFERRING DOCTOR: ____________________

PRIMARY CARE PHYSICIAN: _______________

HOSPITAL AFFILIATION: _________________

PASSWORD: ___________________________
Create a password - required for discussing confidential information.

PASSWORD HINT: _______________________
Provide a hint that will assist you in remembering your password.

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INSURANCE INFORMATION:

[ ] I do not have health insurance
(SKIP TO "AUTHORIZATIONS")

Is your primary insurance an HMO? [ ] Yes [ ] No

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: ____

Claim address: ______________________________________ ____________ _____ __________
CITY STATE ZIP

Is your primary insurance plan through an employer? [ ] Yes [ ] No [ ] Self-Insured

Insured Employer: ____________________________________ Employer phone #: ____________

Name of Insured Employee: ____________________________ DOB of Insured: ______________

Social Security number of Insured: ____________________ Occupation of Employee: ____________

Relationship of Insured to pt: [ ] Self [ ] Spouse [ ] Child [ ] Other: ______________________

OVER

Insurance Group Number: _____________________ Insured Identification #:______________________

Insurance phone #____________________________

I also have a secondary insurance? [ ] Yes [ ] No

ADDITIONAL INSURANCE INFORMATION

Is your additional insurance an HMO? [ ] Yes [ ] No

Additional Insurance Company Name: ____

Claim address: _______________________________________ ____________ _____ ___________
CITY STATE ZIP

Is this insurance plan through an employer? [ ] Yes [ ] No [ ] Self-Insured

Insured Employer: ______________________________________ Employer phone #: ______________

Name of Insured Employee: ______________________________ DOB of Insured: _________________

Social Security number of Insured: _____________________ Occupation of Employee:______________

Relationship of Insured to pt: [ ] Self [ ] Spouse [ ] Child [ ] Other: ________________________

Insurance Group Number: _____________________ Insured Identification #:______________________

Insurance phone #____________________________

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AUTHORIZATIONS

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or the physician rendering services.

Signature:_____________________________________ Date: _________________

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INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the physician rendering services. I have received Nye Partners in Women's Health payment policy and have signed it.

Signature:_____________________________________ Date: _________________

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: My signature below certifies that the above information is complete and correctly stated to the best of my knowledge.

Signature:_____________________________________ Date: _________________