PATIENT REGISTRATION FORM -

MEDICAL RECORD #: _____
(Office Use Only)

FIRSTNAME: _____ MI: _____

LASTNAME: _____

DOB: _____ SS#: _____

AGE: _____ RACE (optional): _____

ADDRESS: _____

_____

_____ _____ _____
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: _____