Account Registration

The Group for Women

PATIENT INFORMATION (PLEASE PRINT / PRESS FIRMLY) ☐ New ☐ Update

Full Name _____ (Last) _____ (First) _____ (MI)

SOCIAL SECURITY # _____ **BIRTHDATE** _____ Race _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____

Employer _____ Occupation _____

Primary Care Physician _____ Phone Number _____

REFERRED BY _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated

SPOUSE, PARENT OR GUARDIAN INFORMATION (Required)

Full Name _____ (Last) _____ (First) _____ (MI)

Social Security # _____ Birthdate _____

Home Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____

Employer _____ Occupation _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other

INSURANCE INFORMATION (Please provide the receptionist with your card to photocopy)

Primary Insurance Name: _____ Effective Date _____

Policy / ID # _____ Group # _____

Claims Address _____ Phone No, _____

Subscriber Name _____ Subscriber SS# _____

Subscriber DOB _____

Secondary Insurance Name: _____ Effective Date _____

Policy / ID # _____ Group # _____

Claims Address _____ Phone No, _____

Subscriber Name _____ Subscriber SS# _____

Subscriber DOB _____

EMERGENCY CONTACT Nearest Friend or Relative not living in your household

Name _____ Home phone _____

Relationship to Patient _____ Work phone _____

As a patient you have certain responsibilities for your care. Those responsibilities include:

- Providing current, accurate billing information at all visits.
- Provide physician with complete medical history.
- Being aware of which benefits your insurance does and does not cover.

I hereby authorize my insurance benefits to be paid directly to *The Group for Women* and I am financially responsible for any balance due. I authorize *The Group for Women* to release any information necessary to process an insurance claim. I will keep my account current as to charges for which I am responsible, in the event that I fail to pay charges, *The Group for Women* is entitled to take whatever action is necessary to collect such charges and I will be responsible for reasonable attorney fees and costs incurred as a result of such collection.

My signature acknowledges understanding and consent to all the above information.

Signature _____ Date _____

Patient or Parent/Guardian if signing for minor