

Women's Health Alliance

PATIENT REGISTRATION FORM

Patient Information

Name (First) _____ (MI) _____ (Last) _____ Age _____

Street address _____ Unit or apt. # _____

City _____ State _____ Zip Code _____

Home phone (_____) _____ Work Phone (_____) _____

Cell phone (_____) _____ Pager (_____) _____

Date of Birth _____ Social Security Number _____

Marital Status (Circle only one) Single Married Divorced Widowed

Email address _____ Employer _____

Emergency Contact Name _____ Phone (_____) _____

Policy Holder (Insurance) Information: Name of Insurance Company: _____

Policy Holder is: Self Spouse Parent/Guardian

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Member ID # _____ Insurance Plan's Group # _____

Policy Holder's Social Security # _____

Policy Holder's Home Address _____

Policy Holder's Employer _____ Work # (_____) _____

Referred by: My Managed Care Directory SWB Yellow Pages 1-800-For- Baylor
 Patient _____ Physician _____ Shepard's Guide
 Mesquite Chamber Friend, not a patient Advertising Lit
 Web Site _____ Mailing Advertisement

If you are in a PPO or HMO, is the physician you are seeing today listed in your plan booklet? Yes No

If you are on Medicare, please present your supplemental insurance card at check-in.

Insurance is a method of payment for services rendered by your physician. It is your responsibility to pay any deductibles, co-pay, or any other balance not paid by your insurance company. Women's Health Alliance does not recognize, accept, or file secondary insurance (except Medicare). Reimbursement from your secondary insurance carrier is your responsibility. You authorize disclosure of your medical records, if needed, to assist reimbursement from the insurance company. I hereby assign all medical and/or surgical benefits to my physician and/or his designated associate. A photocopy or facsimile of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether paid or not paid by said third party or other insurance carrier.

Patient signature

Date

Responsible party's signature

Date