DATE OF APPOINTMENT________________TIME______________PHYSICIAN____________________________

PATIENT REGISTRATION

NAME____

ADDRESS____

CITY________________________________STATE___________________ZIP_____________________

HOME PHONE_________________________CELL____________________WORK__________________

EMAIL ADDRESS____

S.S.#________________________________BIRTHDATE______________AGE____________________

EMPLOYER___________________________OCCUPATION__________________________________

MARITAL STATUS: SINGLE MARRIED DIVORCED OTHER

SPOUSE______________________________SPOUSE EMPLOYER_____________________________

EMERGENCY CONTACT____PHONE__________________

DO YOU AUTHORIZE US TO DISCUSS YOUR MEDICAL INFORMATION WITH ANOTHER FAMILY MEMBER OR FRIEND? YES_____NAME OF PERSON & RELATIONSHIP: ____________________________________
NO______ PHONE NUMBER: ____________________________________
DO YOU AUTHORIZE US TO LEAVE MEDICAL INFORMATION ON YOUR ANSWERING MACHINE OR VOICE MAIL? YES_____PHONE NUMBER__________________________________
NO______

INSURANCE COMPANY NAME____
INSURANCE ADDRESS____
INSURANCE ID#____GROUP#__________________
SUBSCRIBER TO INSURANCE____
SUBSCRIBER DATE OF BIRTH____
SUBSCRIBER SOCIAL SECURITY #____
YOUR RELATIONSHIP TO SUBSCRIBER____

PRIMARY CARE PHYSICIAN____
PHONE NUMBER______________________________FAX NUMBER______________________

PHARMACY NAME AND LOCATION____
PHARMACY PHONE NUMBER____

HOW DID YOU HEAR OF OUR PRACTICE?____

ALL INSURANCES: I hereby authorize WESTERN PA WOMEN'S HEALTHCARE ASSOCIATES to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the services. I understand that I will be personally responsible for all balances unpaid by my insurance carrier. I authorize WESTERN PA WOMEN'S HEALTHCARE ASSOCIATES to furnish complete information regarding services rendered.

SIGNATURE____DATE___________________________