

**PATIENT REGISTRATION FORM—PLEASE COMPLETE IN FULL**

Patient Name (first, middle, last) \_\_\_\_\_

Patient Address \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ ST/Zip \_\_\_\_\_

Phone Numbers: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer Name: \_\_\_\_\_ Status: Full-Time Part-Time None Retired

Employer Address: \_\_\_\_\_

Can you be reached at work? Yes No Student? Full-time Part-time Where? \_\_\_\_\_

***In case of EMERGENCY, please list two people we may contact:***

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST/Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST/Zip: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Policy / ID # \_\_\_\_\_ Member? Self/Spouse/Parent

Insurance Co.: \_\_\_\_\_ Policy / ID # \_\_\_\_\_ Member? Self/Spouse/Parent

***Please complete this section if you are married or your parent's are responsible for insurance coverage:***

Spouse / Parent Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Who referred you? \_\_\_\_\_

I certify the above information to be true and accurate. I authorize my insurance to make payment to Associates for Women's Health directly for all services rendered. I authorize the release of medical records as necessary to process my insurance claims. I understand and agree, regardless of my insurance status, I am responsible for the balance of my account. I am aware and agree there will be a monthly finance charge of 1.5% on any unpaid balances 90 days and over. In addition, I designate your office, employees, and agents as my representative to file grievances in accordance with Indiana Code, Title 27, Chapters 8 and 13.

\_\_\_\_\_  
Patient / Responsible Party Signature

\_\_\_\_\_  
Date

*PAYMENT IS EXPECTED AT TIME OF SERVICE! THANK YOU!*