PATIENT REGISTRATION

Last Name: ___________________________ First Name: _______________________ Date of Birth _________________

Maiden Name: ________________________ Marital Status: ___S ___M ___D ___W Social Security # ______________

Address: _____________________________ Apt. # _______ City: _______________ State: _______ Zip: __________

Home Phone: ______________________ Work Phone: ____________________ Cell Phone: ______________________

Preferred method of contact: (please circle 1) Home # Work # Cell #

Language: ☐ English - Spanish ☐ - Other _____________ Race: _______________ Ethnicity: ___________________

Employer: ___________________________ Occupation: ________________________ Phone: ______________________

Partner's Name: _____________________ Date of Birth: ______________________ Phone: ______________________

PRIMARY CARE PHYSICIAN ____ PCP PHONE: ___________________________

PCP Address ____________________________________ City _________________ State _______ Zip ______________

PHARMACY _______________________________________ PHARMACY PHONE _________________________________

EMERGENCY CONTACT

Name: ___________________________________ Relationship: _________________ Phone: ______________________

INSURANCE INFORMATION

INSURANCE PLAN NAME ____

Insurance Co. Address ________________________________ City __________________ State _______ Zip __________

Policy Holder Name ____ Relationship ____________________________

Policy Holder Date of Birth _______________________

Policy # ____ Group # __________________________________

IF YOU HAVE TWO INSURANCES, PLEASE COMPLETE THE FOLLOWING:

SECONDARY INSURANCE PLAN NAME ____

Insurance Co. Address ________________________________ City __________________ State _______ Zip __________

Policy Holder Name ____ Relationship ____________________________

Policy Holder Date of Birth _______________________

Policy # ____ Group # __________________________________

I hereby authorize release of information necessary to file claim with my insurance company and assign benefits to Southern New England Healthcare for Women (SNEHW). I agree that I will pay any collection or attorney fees and costs incurred in collection of my account by SNEHW. I understand that I am financially responsible all charges not covered by my insurance, including those resulting from my failure to provide the practice with current/updated insurance information or obtain the necessary referral and/or other authorization from my primary care and/or referring physician when required. A copy of this signature is a valid original.

I also acknowledge that the practice has made the Health Insurance Portability and Accountability Act (HIPPA) notice effective April 13, 2003 available to me on the date indicated below.

Signature ____ Date ______________________