WOMEN'S HEALTH ALLIANCE

Physician _____

REGISTRATION SHEET

PATIENT'S LAST NAME | FIRST NAME | MIDDLE INITIAL | SO. SECURITY NO. | AGE | BIRTHDATE

PATIENT'S ADDRESS | CITY, STATE, ZIP CODE | TELEPHONE-HOME

GIVEN NAME OF SPOUSE (HUSBAND OR WIFE) OR PARENTS. IF MINOR RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

☐ MARRIED ☐ SINGLE
☐ WIDOW ☐ DIVORCED

PATIENT'S EMPLOYER | TELEPHONE-WORK | OCCUPATION

SPOUSE'S (OR PARENT'S) EMPLOYER | SPOUSE'S BIRTHDATE | SPOUSE SO. SECURITY NO. | TELEPHONE-WORK

EMERGENCY CONTACT | EMERGENCY PHONE | RELATIONSHIP TO PATIENT

REFERRED BY (FULL NAME) | ADDRESS | TELEPHONE

INSURANCE

Does your insurance allow a routine GYN exam (Well Woman)? Y or N

Do you have a Primary Care Physician? Y or N Does your insurance require a referral? Y or N

If your insurance requires a referral, you are responsible for obtaining it from your primary care physician before your appointment.

PRIMARY INSURANCE CO. _____
(Name) (Address)

POLICY HOLDER _____ SS # INSURED _____

POLICY OR ID # _____ GROUP NAME OR # _____

SECONDARY INSURANCE CO. _____
(Name) (Address)

POLICY HOLDER _____ SS # INSURED _____

POLICY OR ID # _____ GROUP NAME OR # _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any; otherwise payable to me for his services but not to exceed the reasonable and customary charge for those services.

SIGNED (INSURED PERSON) X DATE X

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the physician to release any information acquired in the course of my examination or treatment to any lab, physician, hospital or insurance company.

SIGNED (INSURED PERSON) X DATE X

I AUTHORIZE TRANSMISSION OF MY MEDICAL RECORDS BY FAX IF THE NECESSITY SHOULD ARISE.

SIGNED _____ DATE _____