PATIENT REGISTRATION FORM FOR Twin Springs Ob/Gyn

Patient Name: _____ **SS#:** _____/_____/_____

First Name Middle Name Last Name

Date of Birth: _____/_____/_____ **Age:** ___ **Sex: M/F** Married/Single/Divorced/Widow

Address:

_____

(Street) (City/State/Zip)

Home Phone: _____ **Cell Phone:** _____

Employer Name: _____Employer Phone Number: _____

Employer Address: _____

(Street) (City/State/Zip)

Primary Care Physician: _____ Preferred Pharmacy: _____ Location:_____

How did you hear about our Practice? _____

Race: (circle one) American Indian/Asian/African American/Native Hawaiian/White/other/unknown

Ethnicity: (circle one) Hispanic/Latino/Not Hispanic/ unknown **Language:** English or other_____

Spouse/Guardian Information

Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: (please check): ( ) spouse, ( ) parent ( ) guardian Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: ____ _____

Employer Address: _____

(Street) (City/Street)

Who to call for an emergency:

Name: _____ Address: _____

Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

FIRST INSURANCE INFORMATION

Plan Name: _____

I.D. Number: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F Employer Group_____

Policy Holder's Home Address_____

SECOND INSURANCE INFORMATION

Plan Name: _____

I.D. Number: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F Employer Group_____

Policy Holder's Home Address

Patient Authorization

I hereby authorize **Twin Springs OB/GYN** to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefit due me. I hereby assign payment of said benefit to include Medicare benefits directly to **Twin Springs OB/GYN.** I understand that I am responsible for all charges regardless of insurance status, as well as any associated costs for collection should such action become necessary. I understand that all delinquent charges are subject to monthly interest and or finance charges up to a maximum allowed by state. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

_____I understand that a copy of the privacy policy (HIPAA) is available upon request

Signature: _____ Date: _____