

Patient Registration Form

PATIENT INFORMATION

PLEASE PRINT

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____
Patient Name (Last) _____ (First) _____ (M) _____
Address _____
City/State/Zip _____
Phone # Work _____ Home _____ Cell _____
Marital Status Married Single Divorced Widowed Legally Separated
Social Security # _____ Date of Birth _____ Male Female
 Employed Unemployed Self-Employed Retired FT Student PT Student
Employer _____ Occupation _____
Emergency Contact Name _____ Phone # _____
Emergency Contact Relationship to Patient _____
How Did you Hear of Us _____

RESPONSIBLE PARTY INFORMATION (If same as above skip to next section)

Responsible Party Name (Last) _____ (First) _____ (M) _____
Address Same as patient/or _____
City/State/Zip _____
Phone # Work _____ Home _____ Cell _____
Social Security # _____ DOB _____ Male Female
Employer _____
Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION (present insurance card at front desk)

Name of Primary Insured _____ Relationship to Insured _____
Insured Social Security # _____ Insured DOB _____
Insured Employer Name _____
Insurance Company _____
Subscriber ID (Policy #) _____
Effective Date _____ Termination Date _____ Male Female
Insurance Company Address _____

SECONDARY INSURANCE INFORMATION (present insurance card at front desk)

Name of Primary Insured _____ Relationship to Insured _____
Insured Social Security # _____ Insured DOB _____
Insured Employer Name _____
Insurance Company _____
Subscriber ID (Policy #) _____
Effective Date _____ Termination Date _____ Male Female
Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I hereby assign to Ob/Gyn Associates of Denton, any insurance or other third-party benefits available for healthcare services provided to me. I understand that Ob/Gyn Associates of Denton has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Ob/Gyn Associates of Denton, I agree to forward any health insurance and other third-party payments to Ob/Gyn Associates of Denton that I receive for services rendered to me immediately upon receipt.

Patient Signature _____ **Date** _____
(Or Responsible Party)

****I acknowledge that I have received a copy of the HIPAA Privacy Policies and understand that if I have any questions or complaints, I should contact the Privacy Official _____ (Patient Initials)**