

PREMIER WOMEN'S HEALTH PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME _____ BIRTHDATE _____

HOME ADDRESS _____
STREET APT# CITY STATE ZIP

HOME PHONE () _____ WORK () _____ CELL () _____

EMAIL ADDRESS _____

PHARMACY NAME _____ PHARMACY PHONE _____

EMPLOYER NAME _____ OCCUPATION _____

EMPLOYER ADDRESS _____
STREET CITY STATE ZIP

SOCIAL SECURITY # _____ - _____ - _____ MARITAL STATUS S M D W

SPOUSE/GUARDIAN INFORMATION

SPOUSE NAME _____ GUARDIAN NAME (IF MINOR) _____

BIRTHDATE _____ SOCIAL SECURITY # _____ - _____ - _____

EMPLOYER _____ PHONE # () _____

ADDRESS _____
STREET CITY STATE ZIP

INSURANCE INFORMATION

OFFICE VISIT COPAY: \$ _____

BLUE CROSS BLUE SHIELD: SUBSCRIBER NAME _____

GROUP # _____ COVERAGE CODE _____

CONTRACT# _____ EFFECTIVE DATE _____

MEDICARE: BENEFICIARY NAME _____

MEDICARE CLAIM NUMBER _____ EFFECTIVE DATE _____

PRIVATE INSURANCE COMPANY: _____

SUBSCRIBER NAME _____ CONTRACT # _____ POLICY # _____

INSURANCE CLAIMS ADDRESS _____

PHONE # _____ EFFECTIVE DATE _____

PREVIOUS LAUREL WOMEN'S MEDICAL GROUP PATIENT? YES NO

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

By signing below, I authorize Premier Women's Health to release the medical information necessary to process my insurance claims and authorize payment benefits directly to them. I will be responsible for all charges not covered by my insurance carrier as well as any applicable co-pays and deductible. I also authorize PWH to correspond or confer with my primary care physician regarding my treatment.

PATIENT/GUARDIAN SIGNATURE DATE _____

I have received a copy of the Notice of Privacy Practices.

SIGNATURE DATE _____