

REGISTRATION FORM

(Please Print)

Today's Date:			Primary Care Provider:				
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Email Address:							
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Primary Phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose practice because/referred to by (Please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Television Commercial	<input type="checkbox"/> Found in online search	<input type="checkbox"/> Website	<input type="checkbox"/> Newspaper Ad		
Other family members seen here:							

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Subscriber's Name:		Birth date:	Address (if different):		Home phone no.: ()
Occupation:	Employer:	Employer address:			Employer phone no.: ()
Please indicate primary insurance		<input type="checkbox"/> [Insurance]			
Policy no.:					
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

Assignments of Benefits, Release of Information, & Payment Agreement

- I understand that payment is due at the time of service unless other arrangements have been made. I understand that Women's Health of Central Massachusetts will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to WHCMA.
- I permit WHCMA to release any information deemed necessary to any insurance or third party.
- I agree that I am responsible for full payment of this account. I agree to be held responsible for all attorney fees and court costs in the collection of this account.

Responsible Party Date

Patient's Signature Date

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()