

Client Registration Information

Please PRINT and complete ALL sections below

Client's Personal Information Marital status Single Married Divorced Separated

Name _____
Last First Middle (Apt. # _____)

Street Address _____ State _____ Zip _____
City _____

Home Phone (____) _____ Work Phone (____) _____ Social Security # _____
Date of Birth ____/____/____ Driver's License Number & State _____ Full Time Part time

Employer / Name of School _____
Spouse's / Partner's Name _____
Spouse's / Partner's Social Security # _____ Work Phone (____) _____
How do you wish to be addressed? _____

Client / Responsible Party Information

Responsible Party _____ Date of Birth _____
Relationship to patient: Self Spouse Other Social Security # _____
Responsible party's home phone (____) _____ Work (____) _____
Address _____ (Apt.# _____) City _____ State _____ Zip _____
Employers Name _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____
Occupation _____

Client's Insurance Information Please present insurance card to receptionist

Primary insurance company's name: _____
Insurance address _____ City _____ State _____ Zip _____
Name of insured _____ Date of Birth _____ Relationship to insured _____
Insurance ID number _____ Group Number _____

Secondary insurance company's name: _____
Insurance address _____ City _____ State _____ Zip _____
Name of insured _____ Date of Birth _____ Relationship to insured _____
Insurance ID number _____ Group Number _____

Client's Referral Information

Referred by _____ If referred by a friend, may we thank her or him? _____
Name(s) of other physician(s) who care for you _____

Emergency Contact

Name of person not living with you _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone Number (home) (____) _____ (work) (____) _____

Assignment of benefits - Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to The Woman's Place and any assigning physician for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay for any courtroom and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I hereby agree that a photocopy of this agreement shall be as valid as the original.

Your signature _____ Date _____

Method of payment cash check credit card