Registration Form
Must be Filled Out Completely!! Use Black Ink!!

Name (First) (Middle) (Last)	Maiden Name	Date of Birth	Social Security Number

Address	City	State	Zip Code	Home Phone ( )

Place of Employment	Work Phone ( )	Cell Phone ( )

Marital Status

□ Single □ Married □ Divorced □ Separated □ Widowed

Which telephone number is the best one to contact you with test results? ( )

Can we leave a message? □ Yes □ No

Insurance Information: (Please provide a copy of your insurance card to the receptionist)

Primary Insurance Company	Who holds the insurance	Their Birth Date	Social Security Number	Relationship
I.D. Number	Group Number	Ins. Address, City, State, Zip Code		
Secondary Insurance Company	Who holds the insurance	Their Birth Date	Social Security Number	Relationship
I.D. Number	Group Number	Ins. Address, City, State, Zip Code		

Person to Contact in Case of Emergency

Name	Best Number to Contact Them ( )	Relationship

Primary Care Physician

Name of Physician	Phone Number ( )

Release of Medical Information

If there is anyone we can speak to about your medical concerns please list their names below.
(Examples: mother, father, spouse, sister etc.)

I _____________________ give my permission to release medical information to the following people…

Name	Name	Name

I have received and read the Practice Financial Policy. □ Check Box

I have received and read the HIPAA Notice of Privacy Practices. □ Check Box

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign): All medical information is strictly confidential: however, I hereby authorize NORTHEAST CENTER FOR WOMEN'S HEALTH to furnish medical information to my insurance carrier to process claims or to perform internal administrative functions. I hereby assign to the physician all payments for medical services rendered to myself of my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay the balance in full within thirty days.
By signing this form you are authorizing medical treatment by your physician.

Signature: ____ Date: _______________

Signature: ____ Date: _______________