WOMEN'S HEALTH
of Central Massachusetts

REGISTRATION FORM

(Please Print)

Today's date: / /	Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Email address:		

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:		Social Security no.:	
P.O. Box	City:	State:	ZIP Code:
Home phone no.:	Work no.:	Cell no.:	
Occupation:	Employer:		

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			
Policy no.:		Group no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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*

To whom may we release your medical information?

Spouse_____ Mother_____ Father_____ Child_____ Legal Guardian_____
Other_____

Print their full name:_____
_____

IN CASE OF EMERGENCY

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