

REGISTRATION FORM

(Please Print)

Today's date: / /	Primary Care Provider:
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PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
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.:		
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:	<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

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.: