Caring for You Throughout Life

WOMEN'S HEALTH
of Central Massachusetts

PATIENT REGISTRATION FORM

**Please update and/or provide all information and sign below.* (Please Print)

Today's Date:	Primary Care Provider:								
PATIENT INFORMATION									
Patient's Name:	Email Address:	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐ Widowed							
(Former Name):	Birth Date:	Age:	Sex: ☐ Female ☐ Male ☐ Transgender						
Residential Address:	Cell Phone:	Preferred Phone:	Work Phone:						
Mailing Address:	City:	State:	ZIP Code:						
Race	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White								
Ethnicity	☐ Hispanic or Latino ☐ Non-Hispanic or Latino								
How did you find WHCMA?	Ref by ☐ Dr. «RefPr»	☐ Family	☐ Friend	☐ Insurance	☐ Online search	☐ Website	☐ Newspaper	☐ Hospital	☐ TV Commercial

INSURANCE INFORMATION

(Please give your **driver's license** and **insurance card** to the receptionist.)

Please indicate primary insurance:				
Subscriber's Name:	Birth Date:			
Policy Number:	Group Number:	**«SubscriberGroupNo»**		
Patient's relationship to subscriber:	☐ Self	☐Spouse	☐ Child	☐ Other
Name of secondary insurance (if applicable):	Subscriber's Name:	Policy Number:	Group Number:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Assignments of Benefits, Release of Information, & Payment Agreement

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Women's Health of Central Massachusetts or its assignees. I am responsible for any non-covered services, supplies, co-payments, or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

_____ _____ _____ _____

Responsible Party Date Patient's Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, *Women's Health of Central Massachusetts* originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that *Women's Health of Central Massachusetts* maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this notice is displayed in the waiting room area. I understand that *Women's Health of Central Massachusetts* reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of *Women's Health of Central Massachusetts*. This form acknowledges receipt of this notice.

_____ _____

Signature of Patient or Guardian Date

☐ The patient refused to sign. ☐ Due to an emergency situation, it was not possible to obtain acknowledgement.
☐ Other (please provide details) _____

IN CASE OF EMERGENCY			
Emergency Contact:	Relationship to Patient:	Phone Number:	Alternate Number: