WOMEN'S HEALTH GROUP, INC.

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PATIENT REGISTRATION

PLEASE PRINT

PATIENT: This Section Refers To Patient Only	REFERRED BY
NAME	SOCIAL SECURITY NO
STREET	EMPLOYED BY
CITY STATE ZIP	STREET
AGE BIRTHDATE / / /	CITY STATE ZIP
PHONE # *(Home)* *(Work)*	OCCUPATION
(Cell) *(Email)*	MARITAL STATUS Single☐ Married ☐ Separated☐ Divorced☐ Widowed ☐
Date of last menstrual period / Number of Pregnancies / Number of living children / Miscarriages Abortions	
ALLERGIES	PHARMACY PHONE NO.
PLEASE COMPLETE ALL INFORMATION BELOW	
HUSBAND'S NAME	PHONE: (Home) (Work)
FATHER'S NAME: (if minor)	EMPLOYER
STREET	STREET
CITY STATE ZIP	CITY STATE ZIP
SOCIAL SECURITY NO. BIRTHDATE / / /	OCCUPATION
Name of nearest relative not living with you	RELATIVE'S ADDRESS
PHONE	CITY STATE ZIP
INSURANCE NO COVERAGE ☐	Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one (1) carrier supply information on both carriers. Thank you
1st INSURANCE	2nd INSURANCE
ADDRESS	ADDRESS

CITY	CITY
INSURED (Name on ID Card)	INSURED
POLICY HOLDER (Group, Company name)	POLICY HOLDER (Group, Company name)
GROUP NO.	GROUP NO.
POLICY OR CERTIFICATE NO.	POLICY OR CERTIFICATE NO.
Is Pre-admission authorization required by your insurance company? ☐ Yes ☐ No	Does your insurance require a second opinion for surgery? ☐ Yes ☐ No

I authorize the release of any medical Information necessary to process this claim and/or authorize payment of medical benefits to Women's Health Group for services rendered. I understand that if Pre-admission Authorization and/or a Second Opinion are required by My Insurance Company and **NOT** obtained, my claim could be rejected by such insurance company. In that event, I would be held responsible for the entire amount due to Women's Health Group. I further understand that it is my responsibility to inquire from such insurance company if above information is required and to notifyWomen's Health Group of such. I also acknowledge in the event I do not fulfill my obligation to render my payment in a timely manner, my account could be placed in collections, and all collection and attorney fees would be my responsibility.

Signed_____ Date _____ Review ed _____ Reviewed _____