PATIENT REGISTRATION FORM

(Please Print)

Today's date:	Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Name you wish to be called:	Marital status (circle one) Single / Mar / Div / Sep / Widow / Domestic Partner

Home Phone #	Cell Phone #	OK to leave message? ❑ Yes ❑ No	Birth date: / /	Age:	Social Security #:

Street address:	City:	State & Zip:

Email address:	Primary Language:	Race:	Ethnicity

Occupation:	Employer: (If retired please indicate here)	Employer phone no.: ( )

Referred by:	PCP:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Guarantor of Account:	Relationship to patient:	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Primary insurance:		Effective date:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
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	

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that this is not a guarantee of payment and that I am financially responsible for any balance. I also authorize **Pacific Gynecology and Obstetrics Medical Group** or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*