



Associates In Women's Care, P.C.
Patient Registration

PLEASE USE BLACK INK

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip: _____

Cell Phone #: _____ May we leave messages? Yes ___ No ___

Home Phone #: _____ May we leave messages? Yes ___ No ___

Work Phone #: _____ May we leave messages? Yes ___ No ___

Email: _____

How do you prefer to be contacted? Cell ___ Home ___ Work ___ Email ___ Mail ___

SSN: _____ Preferred Language? _____

Race/Ethnicity (Optional)

Are you Hispanic or Latino? Yes ___ No ___

___ American Indian or Alaska Native

___ Asian

___ African American

___ Native Hawaiian or Pacific Islander

___ White/Caucasian

Emergency Contact or Responsible Party (If Under 18)

Name: _____ Relationship to Patient: _____

Best Phone #: _____ May we leave messages? Yes ___ No ___

Address: _____ State: _____ Zip: _____

Insurance Information *PLEASE COMPLETE FULLY*****

| | |
|--------------------|----------------------|
| Primary Insurance: | Secondary Insurance: |
| Policy/ID#: | Policy/ID#: |
| Group #: | Group #: |
| Subscriber Name: | Subscriber Name: |
| Subscriber DOB: | Subscriber DOB: |
| Subscriber SSN: | Subscriber SSN: |

By signing below I am verifying that I have read and agree to the guarantor's billing agreement on the reverse side of this form.

Printed Name : _____ *Date:* _____

Signature: _____ *Relationship to Patient:* _____