Associates In Women's Care, P.C.

Patient Registration

****PLEASE USE BLACK INK****

Name: _____ Date of Birth: _____
Address: _____
City & 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)

___ Hispanic or Latino
___ American Indian or Alaska Native
___ Native Hawaiian or Pacific Islander
___ Asian
___ African American
___ 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 aggreement on the reverse side of this form.
Printed Name : _____ Date: _____
Signature:_____Relationship to Patient: _____