REGISTRATION FORM

IMPORTANT POLICY NOTICE: Should you need to cancel your appointment, please provide a minimum of 24 hours notice. This helps us to schedule another patient in need of care. Pearl Women's Center policy requires that all patients who are either no-shows or late cancellations be charged a $100 administrative fee. This policy applies to free consultations as well as cash-pay and insurance based visits. Thank you for helping us ensure your fellow patients have equal access to timely, quality care.

Today's Date:______________________

Primary Care Doctor: ______________________

Referring Doctor (if any): ______________________

PATIENT INFORMATION

Patient's Name:______________________ (Last, First, MI)

Legal Name (if different): ______________________ (Last, First, MI)

Maiden Name:__________ DOB:__________ Age: __________ Sex:__________

Home Address:______________________ P.O. Box: ______________________

City:__________ State:__________ ZIP Code:__________

Home Phone: (_______)__________ May we leave confidential voicemail messages at this number? ☐Y ☐N

Cell Phone: (_______) __________ May we leave confidential voicemail messages at this number? ☐Y ☐N

Email address:______________________ Any restrictions on contacting you? ☐Y ☐N

Specify:______________________

Marital status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Separated ☐Widowed

How did you hear about us? ☐Friend/Family__________ ☐Newspaper/Magazine ☐Radio ☐TV ☐Internet ☐Other:__________

Social Security Number:__________

Driver's License #: __________

Employer:__________

Work Phone: (_______) __________

Work Address:__________

City/State/ZIP:__________

Occupation:__________

Spouse/Partner's SSN:__________

Spouse/Partner's Driver's License #:__________

Spouse/Partner's Employer:__________

Spouse/Partner's Work Phone: (_______)__________

Work Address:__________

City/State/ZIP:__________

Occupation:__________

PERSON RESPONSIBLE FOR BILL

☐ Self ☐ Spouse/Partner ☐ Parent/Guardian ☐ Other:____________________

If responsible party is Parent/Guardian or other, please complete the following:

Name:______________________________
Last First MI

Home Address:____________________ P.O. Box:____________________

City:______________ State:__________ ZIP Code:__________

Home Phone: (_____)__________ Cell Phone: (_____)__________ Work Phone: (_____)__________

Employer:____________________ Occupation:______________

INSURANCE INFORMATION

Primary Insurance:____________________

Insurance Address:____________________

Insurance Phone: (_____)______________

Subscriber Name:____________________

Subscriber DOB:____________________

Subscriber SS#:____________________

Plan Name:____________________

Group #:____________________

Policy #:____________________

Out of Network Benefits? ☐ Y ☐ N

Co-Pay $________

Patient's Relationship with Subscriber:__________

Secondary Insurance:____________________

Insurance Address:____________________

Insurance Phone: (_____) ______________

Subscriber Name:____________________

Subscriber DOB:____________________

Subscriber SS#:____________________

Plan Name:____________________

Group #:____________________

Policy #:____________________

Out of Network Benefits? ☐ Y ☐ N

Co-Pay $ ________

Patient's Relationship with Subscriber:__________

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):____________________

Relationship to Patient:______________________________

Home Phone: (_____)__________ Cell Phone: (_____)__________ Work Phone: (_____)__________

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 I am financially responsible for any balance. I also authorize Pearl Women's Center or the insurance company to release any information required to process my claims.

Patient/Guardian Signature:______________________________ **Date:**______________

Printed Name:______________________________