

**WOMEN'S HEALTH CENTER  
PATIENT REGISTRATION FORM**

**PLEASE COMPLETE ENTIRELY**

SOC SEC # \_\_\_\_\_

US CITIZEN?  yes  no

PATIENT NAME \_\_\_\_\_  
(LAST) (FIRST) (MI) (BIRTHDATE)

STREET & PO BOX # \_\_\_\_\_ CITY,STATE,ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EXT \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 MARRIED  DIVORCED  SINGLE  WIDOWED

EMPLOYER NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY,STATE,ZIP \_\_\_\_\_

.....  
SPOUSE **OR** SIGNIFICANT OTHER **OR** PARENT INFORMATION\* (\*If parent information, fill both name sections completely)

NAME \_\_\_\_\_ \*NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ \*ADDRESS \_\_\_\_\_

CITY,STATE,ZIP \_\_\_\_\_ \*CITY,STATE,ZIP \_\_\_\_\_

HM PH \_\_\_\_\_ WK PH \_\_\_\_\_ \*HM PH \_\_\_\_\_ WK PH \_\_\_\_\_

SOC SEC# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ \*SOC SEC# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ \*EMPLOYER \_\_\_\_\_

EMPL ADD \_\_\_\_\_ \*EMPL ADD \_\_\_\_\_  
.....

**PHARMACY NAME \_\_\_\_\_ LOCATION \_\_\_\_\_**

**FAMILY DOCTOR NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_**

**PRIMARY INSURANCE INFORMATION**

**SECONDARY INSURANCE INFORMATION**

INSURANCE NAME \_\_\_\_\_ INSURANCE NAME \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_ GROUP# \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_ GROUP# \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY HOLDER NAME \_\_\_\_\_

POLICY HOLDER BIRTHDATE \_\_\_\_\_ POLICY HOLDER BIRTHDATE \_\_\_\_\_

POLICY HOLDER ID# \_\_\_\_\_ POLICY HOLDER ID# \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I/patient hereby authorize my signature on all insurance and Medicare claim forms at the office of Women's Health Center for payment directly to Dr. Mark F. Morrison or to Dr. Paul W. Morrison for services rendered to me/patient. I authorize this office to release all information with respect to myself or any of my dependents which is necessary or required for the processing of claims under said insurance policy. I/patient understand that I am personally responsible for charges incurred whether my insurance pays or not. I/patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services I/patient received. I agree that this statement applies to all current and future claims.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE DO NOT MAIL - BRING WITH YOU TO YOUR APPOINTMENT ALONG WITH YOUR INSURANCE CARD(S)**

(OVER)

I UNDERSTAND IT MAY BE NECESSARY TO DISCUSS MY MEDICAL INFORMATION WITH PERSONS LISTED BELOW.  
I AUTHORIZE THE FOLLOWING PERSONS MAY BE CONTACTED ON MY BEHALF.

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

---

**SIGNATURE OF PATIENT/GUARDIAN**

**DATE**

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY RIGHTS AND PRACTICES AND HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THAT NOTICE.

---

**SIGNATURE OF PATIENT/GUARDIAN**

**DATE**