REGISTRATION FORM

Today's Date:				
PCP:		Email:		
PATIENT INFORMATION				
Patient's Last name: First:		Middle:		Marital status:
Race:	Ethnicity:	Birth date:	Age:	Sex: ○ M ○ F
Address:				
Social Security no.:	Home phone no.:	Cell phone no.:		
Occupation:	Employer/School:	Employer phone no.:		
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Person responsible for account:	Subscriber's name:	Birthdate:	Address (if different):	
Primary insurance:		Secondary insurance:		
Policy/ID no.:	Group no.:	Policy/ID no.:	Group no.:	
Patient's relationship to subscriber:				
IN CASE OF EMERGENCY				
Name:	Relationship to patient:	Home phone no.:	Work phone no.:	

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to ***Carolina Women's Physicians P.A.*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient/Guardian signature _____ Date _____

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