WOMEN'S HEALTH and Menopause Center

For internal use only

Pt ID
LMP PM N H
Lpap
Labn
DX
Z O A M C G MC W MK

Patient Registration Form

Name:

Birthdate: Cell Phone #: Phone #:

Address:

City: State: Zip Code:

Social Security #: Marital Status: M S D W

Patient's Employer:

Drivers License #:

Employer's Address: Work Phone #:

Medical Insurance Subscriber: Relationship to Patient:

Subscriber's Employer: Work Phone #:

Subscriber's SS#: Subscriber's Birthdate:

Email Address:

Emergency Contact: Name: Phone #:

Address:

Can messages be left at: Work Y or N Home Y or N Primary Care Physician:

Email Address: PCP Phone #:

**Please give the front desk your insurance card(s) to copy for your permanent record. Thank you.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the Women's Health and Menopause Center's **Notice of Privacy Policies** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

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I authorize my health care provider to use an automated telephone system and/or email and to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s) for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient/Guardian Signature Date

Employee Verification Date

How did you hear about us (the www.whmcenter.com site, an internet search engine, phone book, friend, relative or other)? Please let us know:

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If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):

By: (Name and Title):

PRINT RESET