PATIENT REGISTRATION FORM

Cell phone#: _____

Name: _____ **Phone #:** _____

Address: _____ **Birthdate:** _____

City: _____ **State:** _____ **ZipCode:** _____

Social Security #: _____ **Marital Status: M S D W**

Patient's Employer: _____ **Drivers License #:** _____

Employer's Address: _____ **Work Phone #:** _____

Subscriber's Name: _____ **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 number:** _____

Pharmacy Name: _____ **Pharmacy location:** _____

Pharmacy phone #: _____

Circle Please:

Race: American Indian, Asian, African American, Nat Hawiian/Pacific Islander, White, Unknown, Other, Decline

Ethnicity: Not Hispanic or Latino, Hispanic or Latino, Unknown , Declined

Preferred Communication: Email, cell phone, home phone, work phone, text

Appointment confirmations, refills, appointment reminders & normal results will be sent by an automated method.

Would you prefer text message or email? _____

Who were you referred by? _____

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

You have the option to have any statements for balances owed sent to your email address for payment online.
If you would like to enroll in this free service please verify your email address below.

_____ Signature _____

If you would like to opt out please circle OPT OUT Signature _____

Date _____

PATIENT REGISTRATION FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Women's Health Care Physicians' **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:

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 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** _____

Internal Use Only:
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): _____