Evergreen Women's Care Patient Registration

Patient Information Please Print

Name:_____ (Last / First / MI)

_____ Former Name if Applicable

Address:_____ Age:_____ Birth Date:____/____/____ (month / day / year)

Apartment or P.O. Box Number_____ Marital Status: S M D W Sep (circle one)

City:_____ State_____ Zip:_____ Phone Numbers:

Employer:_____ (Name / City / Occupation) Primary #: (_____) _____ (circle one) Home Work Cell

Email address: _____ Alternate #: (_____) _____ (circle one) Home Work Cell

Who referred you to our office?_____ Alternate #: (_____) _____ (circle one) Home Work Cell

OB/GYN Physician:_____ Soc Sec:_____

Family or Primary Care Physician:_____

Family Information Or Financially Responsible Party If Minor Child

Spouse/Partner or Parent Name _____ Relationship to Patient: _____

DOB:____/____/____ Address:_____ (If different than above)

Soc Sec:_____ Employer:_____ (Name / City / Occupation)

Hm Phone: (____)_____ Wk Phone: (____)_____ Cell Phone: (____)_____

Financial And Insurance Information Please Present Insurance Card(s) To Receptionist

Primary Insurance: _____ Secondary Insurance:_____

Group#:_____ Group#:_____

Subscr.#:_____ Subscr.#:_____

Policyholder Name:_____ Policyholder Name:_____

Employee Name: _____ Employee Name: _____

Persons To Contact In Case Of Emergency

Primary Contact:_____ (nearest family member or friend not living with you) Primary Phone:(____)_____ (circle one) Home Work Cell

Relationship to Patient:_____ Alternate Phone:(____)_____ (circle one) Home Work Cell

Alternate Contact:_____ (nearest family member or friend not living with you) Primary Phone:(____)_____ (circle one) Home Work Cell

Relationship to Patient:_____ Alternate Phone:(____)_____ (circle one) Home Work Cell

Release of Benefits & Information: I authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for processing insurance claims. I understand this may include information regarding HIV, sexually transmitted diseases, mental health, drug and/or alcohol use.

_____ DATE:_____
(Patient Signature)

_____ DATE:_____
(Parent Signature if Minor Child)