

# PATIENT REGISTRATION INFORMATION

**Thank you for choosing East Norriton Women's Health Care. Please fill out this form to ensure the best healthcare service to you.**

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female Marital Status:  Married  Single  Widowed  Divorced

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Family Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Family Dr. Address \_\_\_\_\_ Referring Dr. Address \_\_\_\_\_

Employer \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible for Bills (If same as patient do not complete) Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Responsible Party's Relationship To Patient:  Self  Parent  Spouse  Other

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## EMERGENCY CONTACT

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## INSURANCE INFORMATION - PLEASE GIVE CARDS TO RECEPTIONIST TO COPY

PRIMARY INSURANCE \_\_\_\_\_ GROUP# \_\_\_\_\_ ID# \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

SUBSCRIBER NAME (if different) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT  Self  Spouse  Child  Other

SECONDARY INSURANCE \_\_\_\_\_ GROUP# \_\_\_\_\_ ID# \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

SUBSCRIBER NAME (if different) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT  Self  Spouse  Child  Other

If Accident Related Please Provide the Following Information:  Workman's Comp  Auto  Other

### Insurance Carrier Name

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Accident \_\_\_\_\_ State in which Accident Occurred \_\_\_\_\_

### Policy & Claim #

# PATIENT REGISTRATION INFORMATION

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

## ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, including major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to **East Norriton Women's Health Care.**

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

### In compliance with Medicare regulation we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health insurance?      \_\_Yes    \_\_No

Are you entitled to Medicare because of disability or End-Stage Renal Disease?      \_\_Yes    \_\_No

Is the illness or injury the result of an automobile accident or other injury?      \_\_Yes    \_\_No

Has treatment for the accident or illness been authorized by the Veteran's Administration?      \_\_Yes    \_\_No

Are you entitled to any benefits under the Federal Black Lung Program?      \_\_Yes    \_\_No

I certify that this information is true and complete the best of my knowledge.

**FOR OFFICE USE: If all questions are answered "No" Medicare is the primary payor. If any of these questions are answered "Yes", Medicare may be secondary. VERIFY!**