

**Comprehensive Woman's Health, Inc.**  
**Patient Registration**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Please Print Clearly)

Patient's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status: S M D W

Gender M or F

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

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Please circle which number is best to call home/work/cell May a private voice message be left for you YES/ NO

Patient's Employer \_\_\_\_\_

E-mail: \_\_\_\_\_

(Note that use of employer's email is not private)

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

Spouse's/Partner's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's/Partner's Employer \_\_\_\_\_ Work # ( ) \_\_\_\_\_

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

Emergency Contact (Other than Spouse/Partner) \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Preferred method of contact, circle one phone call email USPS mail

**Financial Information**

Financially Responsible Person \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you covered under Medicare? Y or N

Medicare # \_\_\_\_\_

Primary Health Insurance Company \_\_\_\_\_

Secondary Health Insurance Company \_\_\_\_\_

Identification # \_\_\_\_\_

Identification # \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Effective Date \_\_\_\_\_

Effective Date \_\_\_\_\_

**FINANCIAL POLICY:** I certify that the information I have reported is correct. I acknowledge that it is the policy of this office to collect any co-payments or deductibles at the time of each visit. I understand that I am financially responsible for services provided that are not covered by my health insurance. If my insurance requires a referral or preauthorization, I am responsible for bringing the physician referral form. I understand that I may have to pay for services out of pocket if I did not get a required referral or authorization prior to seeing the doctor. In addition, I agree that in the event I do not pay for services provided, I will pay for the cost of collection, and/or court costs and reasonable attorney fees should this be required. I understand that in the absence of a payment plan, outstanding balances may accrue 1.5% interest per month after 30 days.

**CONFIDENTIALITY:** As your physician, it is necessary to communicate in writing, by phone, fax or electronic communication to your primary care physician, or other health care providers, health insurance companies, Medicare/Medicaid or health claims clearinghouses. Communication between your doctors is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information about you be sent to them and you have agreed to release this information as a participating member. The practice will make its best efforts to protect your privacy. This includes nondisclosure of your personal health information for marketing and fundraising purposes.

I understand and agree that my personal health information may be transmitted by computer to laboratories and or consulting health care practitioners to facilitate my medical care. I acknowledge that I have had an opportunity to read the office's Notice of Privacy Practices and Health Care Disclosure Information that contains a description of the uses and disclosures of my personal health information. I understand that this information may be updated and I will be able to see the new information. The policy of this office is to strive to be in compliance with federal and state medical practice guidelines.

A copy of this form can be considered as valid as the original.

Signature of Patient \_\_\_\_\_