

PATIENT REGISTRATION

Please Print

Referred By _____

| | | | | | |
|--|-------|-----|----------|---------------|--|
| PATIENT: This section refer to PATIENT ONLY | | | SEX | DATE OF BIRTH | Marital Status (check box) |
| NAME | RACE | AGE | / | / | <input type="checkbox"/> Single <input type="checkbox"/> Married |
| ADDRESS | | | SSN | | <input type="checkbox"/> Divorced <input type="checkbox"/> Separated |
| | | | | | <input type="checkbox"/> Widowed |
| CITY | STATE | ZIP | EMPLOYER | | |
| HOME PHONE () | | | ADDRESS | | |
| WORK PHONE () | | | CITY | STATE | ZIP |

| | | |
|-------------------|--------|--|
| SPOUSE | D.O.B. | SSN |
| ADDRESS | | OCCUPATION |
| CITY | STATE | ZIP |
| HOME PHONE () | | ADDRESS |
| WORK PHONE () | | CITY STATE ZIP |

| | |
|--|--|
| Primary Carrier Name _____ | Secondary Carrier Name _____ |
| Address _____ | Address _____ |
| Insured _____ | Insured _____ |
| Name on ID Card _____ | Name on ID Card _____ |
| Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |
| Insured ID No. _____ | Insured ID No. _____ |
| Group No. _____ | Group No. _____ |
| or Company Name Insured ID No. _____ | or Company Name Insured ID No. _____ |
| Effective Date _____ | Effective Date _____ |

In order to submit a claim for payment to us for service covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE

Name of Beneficiary _____ H Claim Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **WESTWOOD OB/GYN** for any services furnished me by that physician. I authorized any medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services.

I hereby authorized Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorized release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand that I am financially responsible for any balance not recovered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature _____

Date _____