

Gyn Care REGISTRATION FORM

(Please Print)

Today's Date:	Account #	Primary Care Physician (PCP):
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PATIENT INFORMATION

Patient's last name:	First:	Middle:	Mrs.	Miss Ms.	Marital status (<i>Please check one box</i>):					
Nick name:						Single	Mar	Div	Sep	Wid
Is this your legal name? Yes No	If not, what is your legal name?		Maiden name (<i>if applicable</i>):			Birth date:	Age:	Sex: M F		
Street address:			Social Security no.:			Home phone no.:				
City:		State:		Zip Code:		Email:				
Occupation:		Employer:				Employer phone no.:				
Chose clinic because/referred to clinic by (<i>Please check one box</i>):				Dr.			Insurance plan		Hospital	
Family	Friend	Close to home/work		Yellow Pages		Other:				

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (<i>if different</i>):			Home phone no.:		
Is this person a patient here?	Yes	No					
Occupation:	Employer:	Employer address:			Employer phone no.:		
Is this patient covered by insurance?	Yes	No					
Please indicate primary insurance		Cash	Medicaid	Medicare	Champus	Cigna	
Pinnacle	Tri-Care	Aetna	Blue Cross Blue Shield of LA		Other:		
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		Self	Spouse	Child	Other:		
Name of secondary insurance (<i>if applicable</i>):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		Self	Spouse	Child	Other:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
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The above information is true to the best of my knowledge. I, the undersigned, certify that I (or my dependant) have coverage with the indicated insurance company (ies), and I authorize my insurance benefits be paid directly to the physician. I understand that all accounts are due and payable when the service is rendered. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance and for any balance including any and all counsel, attorney, and court or collection agency fee should my account be turned over for collection. I also authorize Gyn Care or insurance company to release any information and /or medical records required to process my claims and secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature

Date

Relationship to Patient: Parent Legal Guardian Other:

SUBMIT