Omni Women's Health Medical Group, Inc.

PATIENT REGISTRATION (PLEASE PRINT)

PATIENT INFORMATION

Patient's Name: S.S.#:

Date of Birth: Age: Sex: ☐M ☐F Marital Status: ☐Single ☐ Married ☐ Wid ☐ Div ☐ Sep

Home Address: City: State: Zip Code:

Home Phone: Work Phone:

Employer: Occupation:

Work Address

Emergency Telephone Number Other Than Home: Relationship: Name:

SPOUSE/RESPONSIBLE PARTY INFORMATION

Responsible Party: S.S.#:

Address: Home Phone:

Employer: Occupation: D.O.B.:

Work Address:

Work Phone: Driver's License Number:

Spouse's Name: S.S.#:

Spouse's Employer: Occupation: D.O.B.:

Work Address: Work Phone:

INSURANCE INFORMATION

Primary Insurance

Company: Subs. Name:

Address: Subs. #:

Group #:

Secondary Insurance

Company: Subs. Name:

Address: Subs. #:

Group #:

Name of Primary Care Physician:

***Please provide the receptionist with your insurance cards.

CONSENT

I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his\her general agent to give consent for such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action I shall be responsible for any legal fees incurred.

AUTHORIZATION

I have been notified that the physician has an ownership interest in Omni Women's Health Laboratory and Ultrasound. For my convenience, the specimen I provide or myself may be directed to one of these areas. I have been given the opportunity to ask questions regarding this matter.

ASSIGNMENT

I hereby authorize payment directly to the attending physician of any medical / surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

I certify that the information I have reported with regards to my Insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my Insurance company At any time in writing.

How were you referred to our office? ☐ Mailer ☐ Brochure ☐ Friend ☐ Phone book ☐ Insurance List ☐ Other

Who may we thank for referring you? _____

_____ _____

Patient \ Responsible Party Signature **Date**