The Wright Center for Women's Health

Patient Registration

Name: _____ Home Phone: _____

First M.I. Last Work Phone: _____

Street Address: _____ Cell Phone: _____

City/State/Zip: _____ Occupation: _____

Birth date: _____ SS No. _____ Employer: _____

How did you hear about us?: _____

1st Emergency Contact: _____ Home Phone: _____

Relationship to Patient: _____ Work Phone: _____

2nd Emergency Contact: _____ Home Phone: _____

Relationship to Patient: _____ Work Phone: _____

RESPONSIBLE PARTY/MEDICAL INSURANCE INFORMATION

Insured's Name: _____ SS No.: _____

Relation to Patient: _____ Birth Date: _____ Phone No. _____

Employer: _____ Employer Ins. Plan Y N

Carrier Name: _____ Phone No.: _____

If insurance card is not available, please provide address, group/policy number, insurance ID number, copay amt.

Address: _____

I.D. No: _____ Group No. _____ Co-pay Amt. _____

SECONDARY MEDICAL INSURANCE COVERAGE

Insured's Name: _____ SS No.: _____

Relation to Patient: _____ Birth Date: _____ Phone No. _____

Employer: _____ Employer Ins. Plan Y N

Carrier Name: _____ Phone No.: _____

CONSENT FOR TREATMENT, RELEASE ASSIGNMENTS AND FINANCIAL AGREEMENT

I hereby consent to care encompassing routine diagnostic procedures and medical treatment authorized by physicians or other employees or agents of The Wright Center for Women's Health. I authorize any holder of medical other information about me to release any information needed to process my insurance claims and permit a copy of this authorization to be used in place of the original. I also authorize at my request, release of medical records. I authorize payment of medical benefits to The Wright Center for Women's Health and its agents. I take full responsibility for charges not covered by my insurance company and for confirming my physician's participation with my insurance network.

_____ _____

Patient Signature Date

_____ _____

Signature of Gurantor/Relationship to Patient Date