Women's Wellness Center
Registration Form

Personal Information:

First: _____ Middle: _____ Last: _____

Date of Birth: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W SSN: _____

Address: _____ City/State: _____

Zip: _____ Phone: (H): _____ (W) _____ (C) _____

E-Mail Address: _____ May we e-mail you announcements/appointment reminders? ☐ Yes ☐ No

Patient Employer: _____

Patient Occupation: _____

Emergency Contact: _____

Relationship: _____ DOB: _____

Phone: _____

Responsible Party (if different than patient):

First: _____ Last _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

SS # _____ Relationship: _____

Address: _____

City/State/Zip _____

Phone Numbers: _____

Employer:

How did you hear about us? ☐ Yellow Pages ☐ Website/Internet

☐ Friend/Family _____

☐ Dr _____ referred me.

☐ Other _____

Primary Insurance

Employee Name:

Birth Date: SS#:

Address:

Employer Name:

Ins. Co. Name:

Claims Address: Phone:

Group # / Policy#

Secondary Insurance

Employee Name:

Birth Date: SS#:

Address:

Employer Name:

Ins. Co. Name:

Claims Address: Phone:

Group # / Policy#

Insurance Authorization and Financial Responsibility

I authorized Women's Wellness Center (WWC) to furnish information to insurance carriers concerning my care. I also authorize insurance companies to pay WWC directly for their services. I agree to pay WWC for all services rendered to my dependents or myself. I understand that I am responsible for any amounts not covered by insurance. If I have no insurance or am on a plan not accepted by WWC, I understand that I am responsible for all services rendered to my dependents or myself. I understand that I am responsible for all fees charged for returned checks or collection agency fees. **Full payment is due at the time of service.**

Consent to Treat and Medical Records Release Authorization

I authorize WWC providers to provide treatment that they deem advisable for my dependents or me. I understand these services are voluntary and I have a right to refuse these services. In the event of a life-threatening emergency, I consent for the providers to administer emergency treatment. I also authorized WWC to obtain or release medical records and information if they feel it is necessary for my care.

Signature: _____ Date: _____

Insurance Card and ID is required for everyone!!!

Notice of Privacy Practices (HIPAA): Patient Statement of Receipt

I, _____, acknowledge I have had an opportunity to view Women's Wellness Center's Privacy Practices.

Patient Signature: _____ Date: _____