

REGISTRATION FOR CENTER FOR WOMEN'S HEALTH AT EVERGREEN

Name: (Print) _____
Last First MI

Address: _____

Apartment or P.O.Box Number: _____

City: _____ State: _____ Zip: _____

Employer: _____
Name City Occupation

Who referred you to our office? _____

OB/GYN Physician: _____

Have you had services at Evergreen Hospital Before? (Including Lab, X-ray or ER) Yes No

Were you seen under a different name? If yes, please give former name: _____

Prefer to be called _____

Age _____ Date of Birth: _____

S.S. Number: _____

Home Phone #: _____

Work Phone #: _____

Marital Status: S M D W Sep

Primary Physician: _____

FAMILY INFORMATION

Husband/Partner or Parent Name: _____

Home Phone #: _____

S.S. Number: _____

If patient is a minor, with whom does child live? _____

Relationship to patient Birthdate

Work Phone #: _____

Employer: _____

FINANCIAL AND INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Group #: _____

Subscriber #: _____

Policyholder: _____

Ins. Co. Phone #: _____

Please present Insurance card(s) to receptionist

SECONDARY INSURANCE: _____

Group #: _____

Subscriber #: _____

Policyholder: _____

Ins. Co. Phone #: _____

EMERGENCY CONTACT INFORMATION

Next of Kin: _____

Relationship to Patient: _____

Emergency Contact: _____

Relationship to Patient: _____

Home Phone: _____

Work Phone: _____

Home Phone: _____

Work Phone: _____

RELEASE OF BENEFITS AND INFORMATION

I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for my balance due. I authorize the doctor or insurance company to release any information required for processing insurance claims. I understand this may include information regarding HIV, sexually transmitted diseases, mental health, drug and/or alcohol use.

SIGNED: _____

DATE: _____

