Hummel Women's Health

PATIENT REGISTRATION FORM

Name:____

Last First M.I

Name:____

Former Names (Maiden, ETC) Preferred Name (Nickname, ETC)

Birth Date:____________________ Age:______________ SSN:____________

ADDRESS: ____

MARITAL STATUS single married divorced separated widowed

HOME# ( )____________WORK# ( )____________CELL#( )____________

EMAIL: ______________________________________ PRIMARY ☐ HOME ☐ WORK ☐ CELL

EMPLOYED BY: ______________________OCCUPATION: ________________

PRIMARY CARE PHYSICIAN: ______________________________________

REFERRED BY: ______________________ PREFERRED PHARMACY: ______________

Insurance Information Name: ________________**ID#**______________ **Group#**__________

Name of Insured: (Last)______________ (First)______________ (MI)_____

Relationship to Insured: ______________________________

Birthdate:______________________ Employed By:______________________

Name of person to be called in case of emergency:

Name:__________________ Relationship: ______________ Phone:______________

Authorization for Payment: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges.

SIGNED: ______________________________ **Date:** ______________________