

**ASSOCIATES IN WOMEN'S HEALTH CARE
5 MEDICAL PLAZA DR. #250
ROSEVILLE, CA. 95661**

NEW PATIENT OR CHANGES

TODAY'S DATE: _____ 200__

REGISTRATION

PATIENT INFORMATION					
Name (Last/First/Middle)		Date of Birth	Sex	Social Security Number	
AKA (Other Name)		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Divorced			
Mailing Address		Residence Address (If different than mailing address)			
City	State	Zip	City	State	Zip
Home Telephone ()	Cell Number ()		Drivers License Number	E-mail Address	
Employer Name		Occupation			
Employer Address		City	State	Zip	
Employer Telephone ()		Referred By			
RESPONSIBLE PERSON INFORMATION (COMPLETE ONLY IF PATIENT IS NOT FINANCIALLY RESPONSIBLE)					
Responsible Person Name		Date of Birth	Sex	Social Security Number	
Mailing Address		City		State	Zip
Home Telephone ()					
Employer Name					
Employer Address		City	State	Zip	
Employer Telephone ()		Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian			
EMERGENCY INFORMATION					
Name of person to contact in an emergency					
Address		City		State	Zip
Home Telephone ()	Cell Number ()		Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other		
INSURANCE INFORMATION (COPY OF INSURANCE CARD IS REQUIRED)					
Name/Primary Insurance Company			Name/Secondary Insurance Company		
Address			Address		
City	State	Zip	City	State	Zip
Subscriber I.D. #	Plan #	Group #	Subscriber I.D. #	Plan #	Group #
Name of Subscriber		Subscriber Date of Birth	Name of Subscriber		Subscriber Date of Birth
Employer Name			Employer Name		
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other			Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other		
Name of Primary Care Physician		Effective Date			
		ARE YOU ENROLLED IN THE MEDICARE AUTOMATIC CROSSOVER PROGRAM FOR YOUR SUPPLEMENT INS? <input type="checkbox"/> YES <input type="checkbox"/> NO			

How did you hear about us? Health Plan Friend/Family Advertising Referral Service Yellow Pages Other Physician

CONSENT FOR TREATMENT

Initials I authorize the physicians and/or nurse practitioners of Associates In Women’s Health Care to perform and/or order such diagnostic procedures and screenings they deem necessary.

RELEASE OF MEDICAL RECORDS

Initials I authorize Associates In Women’s Health Care to release the following medical information and secure payment of charges from my insurance carrier or its intermediaries.

- _____ Medical condition
- _____ Psychiatric/Mental Health

I agree to be financially responsible fro any services rendered if denied due to my direction to withhold this information from my insurance carrier.

ASSIGNMENT OF BENEFITS

Initials I Authorize my insurance carrier, or its intermediaries, to make payment directly to Associates In Women’s Health Care any medical/surgical/benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Signature

Date

Due to the increasing complexity of all health care programs it has become necessary for our office to place the responsibility of knowing the requirements of your particular insurance policy on you. This includes knowing which facilities can be used for x-rays, laboratory, hospitalization, out-patient surgery or referral to another physician.

- You *must* have your co-pay at the time of service or your appointment will be rescheduled.
- You *must* show your insurance card at *each* visit.

As there are many insurance plans, all with their individual requirements, it is the patient’s responsibility to understand the requirements and limitations of the plan.

Note: All laboratory specimens will be sent to our regular laboratory providers unless you, the patient, advise us the name of the particular laboratory contracted by your insurance company.

I have read and understand the above information

Signature

Date