# EVANSVILLE OBGYN

## REGISTRATION FORM

### PATIENT INFORMATION

| First name: | | | M.I.: | | Marital status: |
|---|---|---|---|---|---|
| Last name: | | | ▭ Mr. ▭ Mrs. | ▭ Miss ▭ Ms. | Single ▭ Mar ▭ Div ▭ Sep ▭ Wid. ▭ |

| Is this your legal name? | | (Legal/Former name): | Birth date: | Age: | Sex: | | Social Security no.: |
|---|---|---|---|---|---|---|---|
| ▭ Yes | ▭ No | | | | ▭ M | ▭ F | |

| Street address or P.O. Box: | Home phone no.: | Cell phone no.: |
|---|---|---|
| | (   ) | (   ) |
| City: | State: | ZIP Code: |
| PCP/Family Doctor: | Employer: | Employer phone no.: (   ) |

| Referred to clinic by: | E-mail: |
|---|---|
| Other family members seen here: | Preferred pharmacy: |

### INSURANCE INFORMATION

| Responsible party : | Birth date: | Phone no.: (   ) |
|---|---|---|
| Relationship to patient: | Employer: | Employer ph. no.: (   ) |

| Name of primary insurance: | | | Subscriber's name: | |
|---|---|---|---|---|
| Group no.: | Policy no.: | | SSN: | Birth date: |
| Patient's relationship to subscriber: | ▭ Self | ▭ Spouse | ▭ Child | ▭ Other |
| Name of secondary insurance (if applicable): | | | Subscriber's name: | |
| Group no.: | Policy no.: | | SSN: | Birth date: |
| Patient's relationship to subscriber: | ▭ Self | ▭ Spouse | ▭ Child | ▭ Other |

### IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
|---|---|---|---|
| | | (   ) | (   ) |

I hereby assign directly to "Evansville OBGYN.", all medical, surgical, and other benefits and proceeds payable under the aforesaid policy of insurance for the services rendered or by reason of the hospitalization described (and all services incidental or relating thereto) to the extent of the charges of "Evansville OBGYN". You are authorized to pay said benefits and proceeds to "Evansville OBGYN."

I hereby authorize any insurance company, employer, hospital, physician, state or federal agency to release all information with respect to myself or any of my dependents which is necessary or required for the processing of claims under said insurance policy. Furthermore, I authorize all agents associated with Evansville OBGYN to contact me on my cellular devices.

I understand and agree that I am personally responsible for all balances owed to Evansville OBGYN either uninsured or deemed not medically necessary and not paid by my insurance. All balances are due at time of service making any unpaid balances delinquent. I agree to pay all cost of collection including but not limited to Third-Party collection agency fees, reasonable attorney fees, court cost and allowable interest.

| | |
|---|---|
| *(Patient/Guardian signature)* | *(Date)* |

### RECEIPT OF NOTICE OF PRIVACY PRACTICES POLICY

I,________________________________________, have received a copy of Evansville OBGYN's Notice of Privacy Practices.

| | |
|---|---|
| *(Patient/Guardian signature)* | *(Date)* |