GynOb associates

373 New Boston Rd. Fall River, MA 02720
Tel: (508) 679-0911 - Fax: (508) 536-0310

## PATIENT REGISTRATION

PATIENT SHOULD COMPLETE WHITE AREAS ONLY

### PATIENT INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PATIENT NUMBER | | | | | | | |
| LAST NAME | | FIRST NAME & INITIAL | | | | | |
| ADDRESS LINE 1 | | | | | | | |
| ADDRESS LINE 2 | | | | | | | |
| CITY | | STATE | | ZIP | | HOME PHONE | |
| DATE OF BIRTH | | SEX | | MARITAL STATUS (M/S) | | REFERRED BY | |
| DOCTOR | | DOES YOUR INSURANCE COMPANY REQUIRE PREAUTHORIZATION? (Y/N) | | | | | |
| ALLOW (Y/N) STMT | | DUN | | INS FORM? | | PURG | TRANSFER? |
| REMARKS | | | | | | | |
| REMARKS | | | | | | | |
| ALLERGIES, IF ANY | | | | | | | |
| PATIENT SOCIAL SEC# | | | | | | | |
| PATIENT'S EMPLOYER | | | | | | | |
| EMPLOYER ADDRESS | | | | | | | |
| CITY | | STATE | | ZIP | | | |
| EMPLOYER PHONE | | EXT | | | | | |

### GUARANTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| RESPONSIBLE PARTY LAST NAME | | FIRST NAME & INITIAL | | RELATIONSHIP | | | |
| ADDRESS | | | | | | | |
| CITY | | STATE | | ZIP | | PHONE | |
| RESPONSIBLE PARTY DATE OF BIRTH | | RESPONSIBLE PARTY S.S NO. | | | | | |
| RESPONSIBLE PARTY EMPLOYER | | | | | | | |
| EMPLOYER ADDRESS | | EMPLOYER PHONE | | | | | |

## INSURANCE INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | PRIMARY INSURANCE OR MEDICARE | | | | | | |
| | MEDICARE OR INSURANCE ADDRESS | | MED. OR INS. #1 PHONE | | | | |
| | POLICYHOLDER LAST NAME | | FIRST NAME | | RELATIONSHIP | | |
| | CERTIFICATE NO. | | GROUP NO. | | MEMBER NO. | | |
| 2 | INSURANCE # 2 | | | | | | |
| | INSURANCE # 2 ADDRESS | | INS. #1 PHONE | | | | |
| | POLICYHOLDER LAST NAME | | FIRST NAME | | RELATIONSHIP | | |
| | CERTIFICATE NO. | | GROUP NO. | | MEMBER NO. | | |
| 3 | INSURANCE # 3 | | | | | | |
| | INSURANCE # 3 ADDRESS | | INS. #1 PHONE | | | | |
| | POLICYHOLDER LAST NAME | | FIRST NAME | | RELATIONSHIP | | |
| | CERTIFICATE NO. | | GROUP NO. | | MEMBER NO. | | |
| | JOB RELATED INJURY (Y/N) | IF YES, PLEASE COMPLETE | DATE OF INJURY | | CLAIM # | | |
| | AUTOMOBILE INJUTY (Y/N) | IF YES, PLEASE COMPLETE | DATE OF INJURY | | ATTORNEY | | |
| | SPOUSE'S NAME | | SPOUSE'S WORK PHONE | | | | |
| | NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU | | RELATIVE/FRIEND PHONE | | | | |

### SIGNATURE

| | | |
|---|---|---|
| AURHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to realease any information acquired in the course of any treatment necessary to process insurance claims. | SIGNATURE (Patient or Parent if Minor) | DATE |
| AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical benefits, if any, otherwise payable to me for his/her service as described realizing that I am responsible to pay non-covered services. | SIGNATURE | DATE |