



Heartland Women's Health Care, P.C.

New Patient Registration Form

<<<pat_PatientName2>>> Preferred Name: Social Sec #:
 <<<pat_AddressLine1>>> Age: <<<pat_Age>>> Date of Birth: <<<pat_DOB1>>>
 <<<pat_AddressLine2>>>
 <<<pat_AddressLine3>>> Home Phone: <<<pat_Home#1>>> Work Phone: <<<pat_Work#1>>>

Marital Status: Single Married Divorced Domestic Partner Widowed

Employer: _____ Occupation: _____

Insurance Co: _____ ID #: _____ Group #: _____ Effective Date: _____

Please have your insurance card (s) available at your appointment so that we may scan this information.

If your insurance is an HMO, please provide the name of your primary care physician: Dr. _____

Emergency Contact: _____ Relationship: _____ Work #: (____) _____ Home #: (____) _____
Other than spouse

IF MARRIED - PLEASE COMPLETE THIS SECTION

Spouse Name: _____ Soc Sec #: _____ Date of Birth: _____

Spouse Employer: _____ Work #: (____) _____

Spouse Ins Co: _____ ID #: _____ Group #: _____ Effective Date: _____

IF A MINOR/ RESPONSIBLE PARTY - PLEASE COMPLETE THIS SECTION

Parent/Guardian: _____ Relationship: _____ Soc Sec #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: (____) _____ Work #: (____) _____ Employer: _____

Assignment of Benefits and Authorization To Release Medical Information

I recognize that the medical insurance I possess may not completely cover the fee(s) for professional services rendered to me, and I agree that I am responsible for said fee(s). I authorize payment directly to and assign to Heartland Women's Health Care, P.C. the medical/surgical benefits, if any, otherwise payable to me for their services. A photostatic copy herof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

I the undersigned authorize Heartland Women's Health Care, P.C. to release my medical information acquired in the course of my examination or treatment to my insurance company(s) or another physician.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Relationship: _____

My signature authorizes Heartland Women's Health Care, P.C. to evaluate and treat this patient.