PATIENT REGISTRATION & HEALTH QUESTIONNAIRE – PLEASE PRINT

This form is to be completed annually

NAME_______________ NICK NAME_______________ DATE OF BIRTH__________

MARITAL STATUS: **S** Yes ☐ No ☐ **M** Yes ☐ No ☐ **W** Yes ☐ No ☐ **D** Yes ☐ No ☐ **SEP** Yes ☐ No ☐

STREET ADDRESS_______________ CITY, ST, ZIP_______________

PHONE # - HOME_______________ WORK_______________ EMPLOYER_______________

CELL PHONE #__________ SS #__________ REFERRED BY_______________

SPOUSE'S NAME_______________ DATE OF BIRTH__________ SS #__________

EMPLOYER_______________ WORK #__________

IF UNDER 18 - PARENT / GUARDIAN_______________

EMERGENCY CONTACT (OTHER THAN SPOUSE)_______________ PHONE__________ RELATIONSHIP__________

Please list any allergies or drug sensitivities_______________

PHARMACY PHONE NO. AND ADDRESS

INSURANCE & BILLING INFORMATION

1. INSURANCE COMPANY_______________ EFFECTIVE DATE__________

   NAME OF INSURED__________ RELATION TO PATIENT__________ GROUP #__________

   INSURED'S DATE OF BIRTH_______________ SS #_______________

2. INSURANCE COMPANY_______________ EFFECTIVE DATE__________

   NAME OF INSURED__________ RELATION TO PATIENT__________ GROUP #__________

   INSURED'S DATE OF BIRTH_______________ SS #_______________

   MEDICARE #_______________ MEDICARE I.D. #_______________

   NAME & ADDRESS OF PERSON RESPONSIBLE FOR BILL_______________

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I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by The Women's Group of Gwinnett, P.C.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to The Women's Group of Gwinnett, P.C. should they elect to receive such payment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Medical records consist of confidential information relating to your health. It is the policy of The Women's Group of Gwinnett, P.C. not to release medical records without the patient's prior written consent. I understand that any request for release of such medical records must be in writing at the time of such request.

_______________ Signature

_______________ Date

PARENT / GUARDIAN (please print)_______________

Signature_______________

Age 16 and under_______________

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