PATIENT REGISTRATION
PLEASE ANSWER ALL QUESTIONS

Patient's Full Name: ______________________________

Mailing Address: ____________________ City/State/Zip: ____________________

Home Number : ____________________ Cell Number: ____________________

DOB: ________ Sex: ______ Patient's Social Security Number: ____________________

Marital status (circle one): single married divorced widowed Occupation ____________________

Patient's Employer: ____________________ Business Phone: ____________________

Spouse: ____________________ Employer: ____________________ Work Phone ____________

Person Responsible for payment: ___Patient ___Spouse ____Parent

Name: ____________________ Address: ____________________

Phone: ____________________ Social Security Number: ____________________ DOB: _______

In Case of Emergency, contact (person not residing with you):

Name: ____________________ Phone: ____________________

Relationship to Patient: ______________________________

Who referred you to us? Dr. ____________________ Family Friend Other __________

DO YOU HAVE MEDICAL INSURANCE? YES NO

NAME OF PRIMARY INSURANCE COMPANY ______________________________

Subscriber's Name ____________________ Date of Birth ____________________

Subscriber's # ____________________ Group # ____________________

IF INSURED, THROUGH WHAT EMPLOYER? ____________________

Do you have Co-Pay Yes No Amount of Co-Pay ____________________

NAME OF SECONDARY INSURANCE COMPANY ______________________________

Subscriber's Name ____________________ Date of Birth ____________________

Subscriber's # ____________________ Group # ____________________

IF INSURED, THROUGH WHAT EMPLOYER ? ____________________

Do you have Co-Pay Yes No Amount of Co-Pay ____________________

AUTHORIZATION TO RELEASE INFORMATION & INSURANCE AGREEMENT/CONTARACT

I hereby authorize BellinghamOB/GYN Associates, P.S. to real ease to my insurance company and medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be pain on my behalf to BOGA. I agree to full responsibility for all expenses incurred by minor child or myself. I understand that a re-billing fee complying with WA State Law will be applied to any overdue balance. In the event ofnon-payment, I will bear the cost of collection and / or court costs and reasonable legal fees should this be required. I understand my provider does not accept assignment on Medicare and I am responsible for any and all charges my insurance does not pay.

SIGNATURE: ____________________ DATE: ____________________

08/31/10