MANHATTAN WOMEN'S HEALTH

REGISTRATION FORM

(Please Print)

Today's date:	Social Security #

PATIENT INFORMATION

Patient Last Name: First: Middle:				Address:	
City	State	Zip code	Home #	Work #	Cell #
Date of Birth: / /	Age:	Email Address:		Referred by:	
Occupation:	Employer:	Employer Address:			
Primary Care Physician	Primary Care Phone #	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow			
Spouse Name (if applicable)	Spouse Employer				
Pharmacy Name:	Pharmacy Phone #				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company Name:

Subscriber's Name	Subscriber's S. S. #	Birth Date: / /	Group #	**Policy #/Member ID**
Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other				
Occupation:	Employer:	Employer address:		Employer phone no.: ( )

Secondary Insurance Company Name: (if applicable)

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group #	**Policy #/Member ID**
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Subscriber's Employer:	Employer Address:			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures, they sometimes refer to as "reasonable and customary fees." We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also, some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance**. In order to control your cost of billings, we do request that our charge for office visits be paid at the initiation of each visit.** In the event the account is turned over for collection, the collection fees and/or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid a an original. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax or hard copy.

✕ _____ _____

Patient/Guardian signature *Date*