

Woman to Woman Gynecology Services

Barbara Patrick, MD

Patient Registration: **PLEASE PRINT**

First Name: _____ M.I.: _____ Last Name: _____

Nickname: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

Work Phone: () _____ Other Phone: () _____

Email: _____

Birth Date: _____ / _____ / _____ Marital Status: Single Married Divorced Widowed

Work Status: Full Part Time Retired Student School: _____ Full Time Part Time

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Primary Phone: () _____ Secondary Phone: () _____

Address: _____

City: _____ State: _____ Zip: _____

Patients Signature: _____ Date: _____

(Over)

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Payment and Insurance Information: **PLEASE PRINT** **PLEASE BRING YOUR INSURANCE CARD(S) TO NEXT VISIT!**

Patients Name: _____ Social Security Number: _____

Primary Insurance: _____ Insurance Phone: () _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Type: Individual Group Medicaid Medicare Blue Cross Blue Shield Other ID#: _____

Group Name: _____ Group/Plan #: _____

Policy Holder: _____ Birth Date: ____/____/____

Relation to Patient: Self Spouse Parent Other _____

Other Insurance: _____ Phone: () _____

Address: _____

City: _____ State: _____ Zip: _____

Type: Individual Group Medicaid Medicare Blue Cross Blue Shield Other ID#: _____

Group Name: _____ Group/Plan #: _____

Policy Holder: _____ Birth Date: ____/____/____

Relation to Patient: Self Spouse Parent Other _____

Guarantor Information (Responsible Party)

First Name: _____ M.I.: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Marital Status: Single Married Divorced Widowed

Home Phone: () _____ Birth Date: ____/____/____ Sex: Male Female

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Status: Full Part Time Retired Student School: _____ Full Time Part Time

Assignment of Benefits, Release of Information and Payment Agreement

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Barbara Patrick, MD (dba Woman to Woman Gynecology Services) will be filling my insurance on my behalf. I agree to have benefits from my insurance assigned to Barbara Patrick, MD (dba Woman to Woman Gynecology Services).

I permit Barbara Patrick, MD (dba Woman to Woman Gynecology Services) to release any information deemed necessary to any insurance or third party.

I agree that I am responsible for full payment of this account. I agree to be held responsible for all fees and cost in the collection of this account.

Responsible Party: _____ Date: _____

Patient: _____ Date: _____