${\it Women's Health care of Southern Indiana, LLC}$

5300 State Road 64, Suite 103 Georgetown, IN 47122 Phone: 812-923-6200 Fax: 812-923-6204

Today's Date ____/ ___ / ___ PATIENT REGISTRATION FORM

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		Student Status - (circle one) Full-Time Student Part-Time Student Not a Student Race - (circle one) Asian African American Hispanic White Other Declined Ethnicity - (circle one) Hispanic or Latino Not Hispanic or Latino Declined						
		Filannacy F	none #					
	Family	Friend He	ospital	Insurance	Website	Other		
ere			-					
Primary Care Doctor Primary Care Phone # RESPONSIBLE PARTY								
ent Guar	antor Self			Check here	if informati	ion is same as patient		
						Primary Phone #		
Dccupation Employer Name & Address NSURANCE INFORMATION **You are responsible for obtaining a referral if you					Employer Phone #			
					erral if you	r insurance requires one. **		
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Group	ID	Patient relati	onship t	o insured: S	elf Spouse	Child Other		
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Group	ID	Patient relati	onship t	o insured: S	elf Spouse	Child Other		
		to Patient	Primary Phone #			Other Phone #		
E BENEFI	TS							
I authorize direct payment of surgical/medical benefits to Women's Healthcare of Southern Indiana, LLC for service rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.								
AUTHORIZTION TO RELEASE INFORMATION								
I hereby authorize Women's Healthcare of Southern Indiana LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.								
Patient/Responsible Party Signature: Date:								
	Group Group Group BENIER cal/medical I understan E INFORM neare of Sor sing applic:	ere ent Guarantor Self Email Addre Employer Na Employer Na Employer Na Employer Na Employer Na Social Secur Group ID Group ID Relationship E BENIEFTIS cal/medical benefits to Wo I understand that I am fina E INFORMATION heare of Southern Indiana sing applications for finan	ere ent Guarantor Self Other Address Email Address Employer Name & Addre **You are responsit e coverage? YES/NO Primary Ins Social Security # Group ID Patient relati Secondary Social Security # Group ID Patient relati Relationship to Patient EBENEFITS cal/medical benefits to Women's Health understand that I am financially respon EINFORMATION heare of Southern Indiana LLC to release sing applications for financial benefits.	ere Primar Primar Primar Primar Primar Primar Primar Primar Primar Address Email Address Employer Name & Address ***You are responsible for of e coverage? YES/NO Primary Insurance Social Security # Date or Group ID Patient relationship t Social Security # Date or Social Security # Date or Primary Patient relationship t Relationship to Patient Primary EBENEFITS Primary Pri	Primary Care Phon Primary Care Phon Primary Care Phon Address Email Address Email Address Employer Name & Address **You are responsible for obtaining a ref e coverage? YES/NO Primary Insurance Name Social Security # Date of Birth Group ID Patient relationship to insured: Secondary Insurance Name Social Security # Date of Birth Group ID Patient relationship to insured: Secondary Insurance Name Social Security # Date of Birth Group ID Patient relationship to insured: Secondary Insurance Name Social Security # Date of Birth Group ID Patient relationship to insured: Secondary Insurance Name Social Security # Date of Birth Cal/medical benefits to Women's Healthcare of Southern Indian I understand that I am financially responsible for any balance r E INFORMATION reare of Southern Indiana LLC to release any medical or incide sing applications for financial benefits.	Primary Care Phone # Address Email Address Email Address Employer Name & Address Employer Name & Address Secondary Insurance Name Social Security # Date of Birth Group ID Patient relationship to insured: Self Spouse Secondary Insurance Name Social Security # Date of Birth Group ID Patient relationship to insured: Self Spouse Relationship to Patient Primary Phone # EBENEFITS Patient for Patient EIST		