Women's Healthcare 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

PATIENT INFORMATION

Patient Name Last First Middle		**Mrs Miss Ms**	**Marital Status** (circle) Single/Married/Divorced/ Separated/Widow
Is this your legal name (circle) YES or NO	If not, what is your legal name?	Birthdate / /	Age:
Street or Mailing Address (circle one) City State ZIP			Primary Phone #
Email Address (to be used for notifications such as patient statements, reminders etc)			Secondary Phone #
Social Security #	Occupation	Employer Name & Address	Employer Phone#

Employment Status - (circle one) Full-Time Part-Time Not Employed Self-Employed Retired Active Military
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
Language - (circle preferred language) English Spanish Other:

Pharmacy:	Pharmacy Phone #
Referred By (please circle) Dr. Family Friend Hospital Insurance Website Other	
Other Family Members Seen Here	
Primary Care Doctor	Primary Care Phone #

RESPONSIBLE PARTY

Responsble Party: Another Patient Guarantor Self Other Check here if information is same as patient

Name	Address	
Date of Birth	Email Address	Primary Phone #
Occupation	Employer Name & Address	Employer Phone #

INSURANCE INFORMATION

****You are responsible for obtaining a referral if your insurance requires one. ****

Does the patient have healthcare coverage? YES/NO		**Primary Insurance Name**	
Name of Insured	Social Security #	Date of Birth	Effective Date
Subscriber ID (Policy Number)	Group ID	Patient relationship to insured: Self Spouse Child Other	
		Secondary Insurance Name	
Name of Insured	Social Security #	Date of Birth	Effective Date
Subscriber ID (Policy Number)	Group ID	Patient relationship to insured: Self Spouse Child Other	

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Primary Phone #	Other Phone #

ASSIGNMENT OF INSURANCE BENEFITS

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:**