Bethany Women's Healthcare
Patient Registration Information

Name:_____ Date of Birth:_____ Age: ____
(Last) (First) (Initial)

Address:_____ City,State, Zip: _____

Social Security Number:_____ Marital Status: □ Single □ Married □ Divorced □ Widow

E-Mail:_____ Primary Phone:_____ Secondary Phone:_____

Language	Race	Ethnicity
☐ English	☐ American Indian or Alaskan Native	☐ African
☐ Cantonese	☐ Asian	☐ Ashkenazi Jew
☐ Italian	☐ Black or African American	☐ Chinese
☐ Spanish	☐ Hispanic	☐ European
☐ Vietnamese	☐ White	☐ Filipino
☐ Other:_____	☐ Unknown	☐ Hispanic or Latino
	☐ Other:_____	☐ Indian
	☐ Not Provided	☐ Japanese
		☐ Mediterranean
		☐ Middle Eastern
		☐ Vietnamese
		☐ Unknown
		☐ Not Provided

Primary Care Physician:_____ Phone: _____

Emergency Contact:_____ Relationship: _____

Primary Phone:_____ Secondary Phone:_____

Employer:_____ Occupation:_____ Work Phone: _____

Employer Address:_____ City, State, Zip: _____

Employer Phone:_____ Referred to our office by:_____

Spouse (if married) or Parent (if minor)

Name:_____ Relationship: _____ Date of Birth:_____

Address:_____ City, State, Zip:_____

Primary Phone:_____ Secondary Phone:_____

Employer:_____ Social Security Number: _____

Insurance Information

Primary Insurance:_____

ID#:_____ Group #:_____

Policy Holder:_____

Policy Holder DOB: _____

Relationship to Patient: _____

Specialist Copay Amount: _____

Date I became effective on this insurance: _____

Secondary Insurance:_____

ID#:_____ Group #: _____

Policy Holder:_____

Policy Holder DOB:_____

Relationship to Patient:_____

Specialist Copay Amount:_____

Date I became effective on this insurance:_____

Reason for today's visit:_____

(OVER)

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Assignment, Authorization & Consent to Treat

I acknowledge that all of the above information is true and correct. It has been furnished to this office with full knowledge that I agree to prompt payment of all fees and charges for treatment and services rendered upon presentation of the billing statement unless payment arrangements are agreed upon in advance in writing. I will be responsible for all collection costs if my account is sent to a collection agency. Patient hereby waives her confidentiality rights should collection action become necessary. I hereby authorize and request that payment under my insurance plan(s) be made directly to Bethany Women's Healthcare, P.C. for services rendered to me, and I am financially responsible for non-covered services.

I authorize the release of any information required to process insurance claims including any information referring to alcohol, drug abuse, and /or AIDS. I authorize the release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians and others involved in the medical and/or financial aspects of my care. This authorization may be revoked in writing by me at any time.

I hereby consent to the administration and performance of all diagnostic procedures and /or treatments which, in the judgment of Bethany Women's Healthcare, P.C. may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedures, or referral. I have the option to decline such treatment and/or seek further information.

Signature of Responsible Party:_____ Date:_____

Printed Name:_____

BWH Representative:_____Date Verified:_____