ELITE
WOMEN'S CARE

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PHONE: (847) 781-1894

PATIENT REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (FIRST - MI - LAST) (Or Parent/Guardian of Dependent named below)	DATE OF BIRTH / /	AGE	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed
STREET ADDRESS	HOME PHONE NO. ( )	CELL PHONE NO. ( )	
CITY - STATE - ZIP	SOCIAL SECURITY NUMBER / /	E-MAIL	
EMPLOYER	OCCUPATION	EMPLOYER'S PHONE NO. ( )	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP
SPOUSE OR (PARENT IF MINOR)	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER / /	
EMPLOYER	OCCUPATION	EMPLOYER'S PHONE NO. ( )	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACTS

IN CASE OF EMERGENCY, NOTIFY	EMERGENCY CONTACT'S PHONE NO. ( )

MISCELLANEOUS INFORMATION

PRIMARY PHYSICIAN	DID HE/SHE REFER YOU?	PHYSICIAN'S PHONE NO. ( )
HOW DID YOU HEAR ABOUT US? ☐ FRIEND ☐ PRIMARY CARE PHYSICIAN ☐ MARKETING ☐ WEBSITE ☐ OTHER _____		

INSURANCE CARD HOLDER INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME	INSURANCE COMPANY NAME
SUBSCRIBER NAME ☐ SELF ☐ SPOUSE ☐ CHILD	SUBSCRIBER NAME ☐ SELF ☐ SPOUSE ☐ CHILD

HEALTH CARE REFORM QUESTIONS

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

_____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian
_____ Black or African
_____ White
_____ Hispanic
_____ Other Race _____

ETHNICITY:
_____ Hispanic
_____ Non-Hispanic
_____ Unreported/Refused to Report

LANGUAGE _____

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, hereby give my consent to Elite Women's Care to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.

I acknowledge receipt of the Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that Elite Women's Care has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Elite Women's Care. I also understand that I will not be able to revoke this consent in cases where Elite Women's Care has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Elite Women's Care.

Financial Policy

I have been given this policy. My signature below indicates that I have read, understand and will comply with the information contained within the financial policy.

Susan Orhan, M.D., P.C./Elite Women's Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-847-781-1894.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-847-781-1894.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-847-781-1894.

Signed: _____ Date: _____ / _____ / _____

If you are not the patient, please specify your relationship to the patient _____

POS Reorder # 1823828