Women's Healthcare Consultants of Gwinnett, PC

PATIENT REGISTRATION

Name: _____ Date of Birth: _____ SS#: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Home#: _____ Work#: _____ Cell#: _____

E-mail Address: _____ Driver's License #: _____

Marital Status: S___ M ___ W ___ D ___ Sep ___ Employer: _____ PCP: _____

Spouse (or if Minor/Parent Name) _____ Birthdate: _____ SS #: _____

Driver's License: _____ Employer: _____ Employer Telephone #: _____

EMERGENCY CONTACT

(OTHER THAN SPOUSE/PARENT)

Name: _____ Home #: _____ Work#: _____

Address: _____ Relationship: _____

INSURANCE INFORMATION

Insurance Co: _____ Policy Holder's Name: _____

Relationship: _____ SS# _____ Birthdate: _____

Member ID# _____ Group# _____ Employer: _____

Authorization For Release Of Information- I hereby authorize Women's Healthcare Consultants of Gwinnett to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

ASSIGNMENT OF BENEFITS- I hereby authorize direct payment of medical/surgical benefits to Women's Healthcare Consultants of Gwinnett for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. I hereby guarantee the payment of all accounts for services rendered. I hereby waive all claims of exemption under the State of Georgia and agree to pay, if necessary, all cost of collection, including attorney's fee.

Signature: _____ **Date:** _____