Physicians Surgeons for Women

REGISTRATION FORM

Patient Information

Last Name	First Name	MI	Date of Birth	SS #
Street Address	City		State	Zip
Home Phone	Work Phone	Cell Phone	Sexual orientation	Marital Status Circle One Single Married Widow
Email Would you like to receive practice information? Y or N		Gender Identity		Race
Employer	Employers Address	City		State/Zip
Referring Physician	Address	Phone		
Pharmacy Name	Address	Phone		

Responsible Party: (If different from above)

Last Name	First Name	MI	Date of Birth	SS#
Street Address	City		State	Zip
Email	Phone	Work Phone	Relationship to Responsible Party: Circle One Self Spouse Child Parent Other	
Employer	Employers Address	City	State/Zip	

Emergency Contact Information

Name	Home Phone	Relationship
Address	Cell	D.O.B.

Insurance/Policy Holder Information: (Please present insurance cards to receptionist) Required for billing purposes

Primary Insurance	Policy Holder Name		Policy Holder Birthdate	Employer
Effective Date	Group #	ID Number	Relationship to Patient: Circle One Self Spouse Child Parent Other	SS #
Secondary Insurance	Policy holder name		Policy Holder Birthdate	Employer
Effective Date	Group #	ID Number	Relationship to Patient: Circle One Self Spouse Child Parent Other	SS#

Privacy Policy:

I acknowledge that I have received a copy of the privacy policies of Physicians and Surgeons for Women, Inc.

AUTHORIZATION FOR TREATMENT:

I authorize examination, diagnosis and general treatment (including but not limited to, the use of ultrasound and other non-invasive procedures and diagnostic tests) to be performed by physicians and staff pf PSFW, Inc. I realize that if a medical procedure or surgery is required that I will be given additional information.

_____ _____

Patient Signature Date

Physicians + Surgeons for Women

Our Mission: Compassionate care for all women.

Our Promise to You…

- To treat all of our patients with **compassion and understanding** when dealing with their healthcare needs
- **Availability** of our healthcare team for issues and emergent problems
- **Quality and Innovative care** for your healthcare needs
- **Faith based, family-oriented** practice where your healthcare needs are our primary concern.

Our Expectations of our Patients:

- To be **open and honest** about all aspects of your health so that we can best serve you
- To **follow your plan of care** as discussed with your physician
- To **keep your scheduled appointments**
- To **be on time** for all scheduled appointments
- To treat all staff and physicians with **respect and good manners**
- To arrive 10 minutes prior to your Ultrasound appointment as directed at time of scheduling.
- Children under the age of 14 must be accompanied by an adult at all times.
- To be **forthcoming** in providing all needed insurance information pertaining to your services
- To contact the practice to discuss payment plans, discounts or other financial avenues available if you have issues meeting your financial responsibility pertaining to your account

I understand the above information as it pertains to the practice expectations and that I am a responsible patient and will abide by the above guidelines.

_____ _____

Patients Name (Printed) Date

_____ _____

Patient Signature Witness Signature