Martin, Lee & Page OBGYN **PATIENT REGISTRATION**

INFORMATION – Please Complete All Sections

Preferred Provider	Last Name	First Name	
Date of Birth	Mailing Address		
SSN	Mailing City	Mailing State	Mailing Zip Code
Employer	Employer Address		
Home Telephone ❑ Preferred	Work Telephone ❑ Preferred	Cellular Phone ❑ Preferred	
❑ Single ❑ Married ❑ Divorced ❑ Widowed Marital Status	Spouse Name/SSN	Pharmacy Phone Number	
Emergency Contact	Emergency Contact Telephone	Patient e-mail Address	

Primary Insurance Company	Group Number	Policy Number
Policy Holder	Policy Holder Date of Birth	❑Self ❑ Spouse ❑ Child ❑ Other (specify) Relation to Policy Holder
Primary Insurance Mailing Address		Insurance Telephone
Secondary Insurance Company	Group Number	Policy Number
Policy Holder	Policy Holder Date of Birth	❑Self ❑ Spouse ❑ Child ❑ Other (specify) Relation to Policy Holder
Secondary Insurance Mailing Address		Insurance Telephone

Primary Care Physician – Name and Address	Primary Care Physician Telephone

Would you like Martin, Lee & Page OBGYN to provide updates on your care and treatment to your primary care physician? ❑ No ❑Yes

How did you hear about Martin, Lee & Page OBGYN? ❑ Already a Patient ❑ Another Patient _____ ❑ Radio
❑ Another Doctor _____ ❑ Phone Book ❑ Magazine / Newspaper _____ ❑ Web Site ❑ Other _____

Release of Information

The patient (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the Martin, Lee & Page OBGYN for the purpose of treatment, payment or health care operation, including submission of a claim for medical benefits to a administrator of medical benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a medical plan. You are entitled to a copy of this consent. This consent may be revoked in writing delivered to your Martin, Lee & Page OBGYN, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign this consent, Martin, Lee & Page OBGYN may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided below.

Assignment of Benefits

I authorize payment of any insurance benefits for services rendered by Martin, Lee & Page OBGYN to be paid directly to Martin, Lee & Page OBGYN and its physicians.

Financial Agreement

I understand that verification of insurance benefits and authorization for services is not a guarantee of payment in full for services rendered by Martin, Lee & Page OBGYN. I understand that I am fully responsible for payment for services rendered by Martin, Lee & Page OBGYN. I agree to pay any applicable copayments, deductibles, and coinsurance amounts at the time services are rendered, unless prior arrangements are made with Martin, Lee & Page OBGYN. I understand that Martin, Lee & Page OBGYN may refer any unpaid balance to a collection agency for resolution. I understand that I will be responsible for the costs of collection, legal fees and other costs incurred in collection of my balance in addition to my account balance with Martin, Lee & Page OBGYN .

❑ I would like to receive e-mail notices and newsletters from Martin, Lee & Page OBGYN

Authorized Signature	Date
Name of Authorized Signatory, if not Patient	Relationship to Patient ❑ Parent ❑ Legal Guardian ❑Other _____

MARTIN, LEE & PAGE OB GYN

Kyle P. Martin, MD ● Helen S. Lee, MD ● Audrey M. Page, MD
Lauren L. Beavers,APRN,BC