VIRTUOSA GYN

REGISTRATION FORM

Today's Date: [Date] PCP: [PCP]

PATIENT INFORMATION

Patient's Last name: First & Middle: Marital status:

Is this your legal name? If not, what is your legal name? Maiden name: Birth date: Age: Sex:

☐ Yes ☐ No ☐ M ☐ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.: Home phone no.: Cell phone no.:

Occupation: Employer: Employer phone no.:

Referred to clinic by (Please choose one option):

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.:

Is this person a patient here? ☐ Yes ☐ No Is this patient covered by insurance? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

Patient Name: _____ ***Date of Birth:*** _____

Consent for Treatment:

I understand that my health condition requires outpatient admission. I authorize and consent to treatment as ordered by my physician.

Initial:
Date:

Consent for Photo and Study:

I authorize and consent to Virtuosa, PLLC and/or Dr. Susan A Crockett to use my photo of procedures done by Dr. Susan A Crockett for studies, educational teachings, journals and presentations.

Initial:
Date:

Release of Medical information:

I consent to release of all my medical records, without limitation, to any insurance company or other party which may be responsible for payment of all or part of my medical expenses.

Initial:
Date:

Attendance Policy:

We respectfully request 24 hours advance notice of appointment cancellations. If appointments are not kept, your treatment, prescriptions or future care may be terminated after the third no show.

Initial:
Date:

Patient Bill of Rights:

I certify that I have received a copy of the Patient's Bill of Rights prior to being seen in the clinic.

Initial:
Date:

Notice of Privacy Practices:

I certify that I have received a copy of the "Notice of Privacy Practices" prior to being seen in the clinic.

Initial:
Date: