Please Print

NEW PATIENT REGISTRATION-TOTAL WOMEN'S HEALTH & WELLNESS CENTER

Today's Date		**e-mail address**

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)	
Address (Number) (Street) (Apt. No.)					
City	State	Zip	Social Security No.	Home Phone	
Date of Birth	Age	Sex	Marital Status	Occupation	
Employer Name	Employer Street Address		City	State	Zip
Business Phone (Including Extension)			Patient's Driver's License No.	State	
Other Physicians You See					
How Did You Hear About Us?					

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)					
Address (If Different From Above)	City	State	Zip	Home Phone	
Employer Name	Street Address	City	State	Zip	Business Phone (Ext)

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Subscriber Name	Where to Send Claim	
Secondary Insurance Company Name	Group No.	ID/Certificate No.
Subscriber Name		
Other Insurance Information		

EMERGENCY INFORMATION

Person to Notify in Case of Emergency			Relationship
Address (Number) (Street) (Apt. No.)			
City	State	Zip	Home Phone

INFORMATION FOR THE PATIENT

- 1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.
3. If you have any questions we will, of course, be happy to assist you.

Signature: