



NEW PATIENT REGISTRATION FORM:

Please have your ID and Insurance Card available for Copying during your appointment.

Patient Information

Last Name: _____ First Name: _____ MI _____
 Address: _____ City: _____ State: _____ Zip _____
 Email Address: _____ com or net Preferred Language: _____
 Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian
 White Refused to Report/Unreported Other Pacific Islander More than One Race
 Ethnicity: Hispanic or Latino Not Hispanic or Latino Refused to Report
 Check Appropriate Box: Minor Single Married Widowed Separated Divorced
 Home Phone: (____) _____ Work Phone (____) _____ Cell Phone (____) _____
 The best time to contact me is: A.M. P.M. Leave Message on my Home Phone Work Phone Cell Phone
 Date of Birth: ____/____/____ Social Security Number: _____
 The Name of the person we can we notify in case of an Emergency: _____
 Emergency Phone Number: (____) _____ Relationship to Patient: _____
 Your Primary Care Physician: _____ How did you hear about out Office? _____
 Do you have a Living Will or Advance Medical Directive? : Yes No

Insurance Information – Please have your insurance card available for copying when you are in the office. The staff at Prince William OB/GYN will assist patients but is not responsible for knowing each individual’s insurance coverage.

Insurance Information

Name of Primary Insurance Company _____ SSN number of Subscriber: _____
 Primary Holder of the Primary Insurance: _____ DOB ____/____/____
 Address: _____ City: _____ State: _____ Zip _____
DO YOU HAVE A SECONDARY INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING
 Name of Secondary Insurance Company _____ SSN number of Subscriber: _____
 Primary Holder of the Secondary Insurance: _____ DOB ____/____/____
 Address: _____ City: _____ State: _____ Zip _____

Insurance Authorization and Assignment/Privacy Statement

Privacy Statement: I understand and agree that medical information may be released in the course of my care in accordance with the HIPAA Privacy Notice.

I hereby authorize this office to apply for benefits on my behalf for covered services rendered and I hereby irrevocably assign to the above named provider all payments for medical services rendered. In the event my account is placed in collection, I agree to pay all costs and expenses including collection or attorney fees related to the collection thereof.

I understand that I am financially responsible for all co-pays and any charges for services whether or not covered by my insurance company. Payment is expected at the time of service unless prior arrangements have been made. I also understand that I am responsible for knowing the requirements of my insurance policy and any changes in my insurance benefits or co-payments. A copy of this authorization shall be considered as valid as the original.

Permission is given (please initial: Yes ____ No ____) for Prince William OB/GYN to leave routine exam results on (Please check all that apply) Home Answering Machine Work Voice Mail Home Email Work Email

Signature of Patient: _____ **Date:** _____