

## SEASONS OB/GYN REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Email Address:	Primary Phone: (   )	Home Phone: (   )		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Cell Phone: (   )	
P.O. Box:	City:		State:		ZIP Code:	
Occupation:	Employer:			Employer phone no.: (   )		
Spouse's Name:			Spouse's DOB:   /   /		Spouse's Employer:	

<b>INSURANCE INFORMATION</b>					
(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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:			Employer phone no.: (   )
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone : (   )	Work phone : (   )
<p>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 Seasons OB/GYN or insurance company to release any information required to process my claims. I also understand my right to file a complaint with my insurance carrier. I also authorize Seasons OB/GYN to evaluate and treat me for any condition I present with. I understand that any unpaid balance could generate a late fee and be turned over to an outside collection agency.</p>				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	