# SHEA WOMEN'S CARE
# PATIENT REGISTRATION FORM

Physician Selection: Andrew W. Carter MD / Brenda A. Martin MD

**Please completely fill out this form.**

| | | | | |
|---|---|---|---|---|
| Name:(Last) | | (First) | | (MI) |
| Address: | | (City, State, Zip) | | |
| Date of Birth: | SSN: | Marital Status Single | Sex: female | Student: Full/Part |
| ******** ***Primary Contact Number for appointment confirmation:*** _____ ******** | | | | |
| □**Home Phone #:** Leave Message: Yes/No | | □**Cell Phone #:** Leave Message: Yes/No | | □**Work Phone #:** Leave Message: Yes/No |
| Employer: | | | Employed: Full/Part/Retired/None | |
| Employer Address: | | | | |
| Patient's E-mail address: | | | | |
| Spouses Name | | Date of Birth: | | SSN: |
| Emergency Contact: | | Relationship: | | Phone #: |
| Pharmacy Name/Phone Number/Location: | | | | |

**RESPONSIBLE PARTY:** *(If someone other than the patient is financially responsible, i.e. Patient is a minor.)*

| | | |
|---|---|---|
| Name: | | Relationship: |
| Address: | | |
| SS#: | Home Phone: | Work Phone: |

**INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)**

| | | | |
|---|---|---|---|
| **Primary Insurance** : | I.D. #: | Group # | Effective Date |
| Name of Subscriber: | Subscriber's Date of Birth: | | Relationship to Patient: Self - patient is the insured |
| Subscriber's Home Address: (if different from patient's) | | | Phone #: |
| Subscriber Employed by: | | | Phone #: |
| **Secondary Insurance** : | I.D. #: | Group # | Effective Date |
| Name of Subscriber: | Subscriber's Date of Birth: | | Relationship to Patient: |
| Subscriber's Home Address: (if different from patient's) | | | Phone #: |
| Subscriber Employed by: | | | Phone #: |

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS DECLARATION / INFORMATION VERIFICATION
I or my representative, recognizing the need for care, consent to all and any services as ordered by my physician, including, but not limited to, laboratory tests, medical or surgical treatment, examination, and other services rendered under specific instructions of my physician. I authorize and request that payments under my medical insurance programs be made directly to the above provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

Signature: _____ Date: _____