Patient Registration Form

**** Please Print and <u>DO NOT</u> leave anything blank****

Name: _____ DOB: _____

Address: _____APT#____ City_____ State ____ZIP_____

Phone (H) _____ (C) _____(W)_____

Material Status __S ___M___D___W Religion_____

Primary Care Physician: _____

Pharmacy _____ Telephone #: _____

Employer: _____

Emergency Contact Person: _____ Phone: _____

<u>RESPONSIBLE PARTY FOR BILLING (IF PATIENT IS MINOR)</u>

Name: _____Relationship_____

Address: _____APT# ___ City _____State___ Zip_____

INSURANCE:

**Please fill out even though you have given us your card, always present your insurance card at each visit; failure to do so may result in patient financial responsibility for services rendered

<u>Primary Insurance</u>

Insurance Name:_____

Insured Name: _____ DOB of insured: _____

Identification #: _____ GROUP # _____ (if applicable)

<u>PLEASE TURN OVER and COMPLETE OTHER SIDE</u>

****Please print and <u>DO NOT</u> leave anything blank****

<u>Secondary Insurance</u> (if applicable)

Insurance Name: _____

Insured Name: _____ DOB of insured: _____

Identification #: _____ GROUP #: _____ (if applicable)

<u>INSURANCE, MEDICAL RELEASE AND ASSIGNMENT</u>

I, the undersigned, certify that I (or my dependant) have insurance and assign directly to Lee Gynecology. All insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby, authorize the doctor to release all information necessary to secure the payment of my benefit. I authorize the use of the signature on all insurance submission.

_____ _____

Signature of Patient or Guardian Date

<u>MEDICARE RELEASE</u>

I, the undersigned, certify that the information under title XVIII of the social security act is correct. I authorize any medical information about me be release to the social security administration, or it carriers, any information requested to process my claims. I have assigned all payments to be paid to my provider.

_____ _____

Signature of Patient or Guardian Date

<u>RELEASE OF INFORMATION</u>

I authorize and allow Lee Gynecology having treated me, to release to any governmental agencies, hospitals, insurance carriers, or any other financial liability carrier to make copies of all my medical records, including HIV, relating to my care and treatment, if needed for medical treatment, healthcare operations and to substantiate payment of my care.

_____ _____

Signature of Patient or Guardian Date

LAB RELEASE FORM

****Please print and DO NOT leave anything blank****

Certain laboratory tests are performed in house (Example: Lab work, biopsy, cultures or pap smears), while others must be sent out for processing. For those tests that are required to be sent out the *PATIENT* is responsible for letting the office know what hospital they would them to be sent to. **I authorize my tests to go to: _____ UHS (Wilson) or _____LOURDES**

_____ _____

Signature of Patient or Guardian Date

HIPPA PRIVACY INFORMATION

May we leave appointment information on (circle one)

Home Telephone	YES / NO	If you answer "NO" you will not get a reminder call
Cell Phone	YES / NO	If you answer "NO" you will not get a reminder call
Cell Text	YES / NO	
Work Phone	YES / NO	
Send Through Mail	YES / NO	If you answer "NO" you will not get a reminder letter
Send Through Email/Portal	YES / NO	
With Another Person	YES / NO	

If "YES": Name _____ Relationship _____ Phone_____

Additional Names:

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

May we leave medical information in detail on (circle one)

Home Telephone	YES / NO	If you answer "NO" you will not get a reminder call
Cell Phone	YES / NO	If you answer "NO" you will not get a reminder call
Cell Text	YES / NO	
Work Phone	YES / NO	
Send Through Mail	YES / NO	If you answer "NO" you will not get a reminder letter
Send Through Email	YES / NO	
With Another Person	YES / NO	

If "YES" Name _____ Relationship _____ Phone_____

Additional Names:

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

___I acknowledge that I was offered/given a copy of the privacy notice.

_____ _____

Signature of Patient or Guardian Date