southdale obgyn

Patient Registration Form

Account #________________________

PATIENT INFORMATION

Name Last	Middle	First	Preferred/Nickname

Maiden	Prefix (Circle One) Miss Mrs. Ms	Age	DOB

Marital Status (Circle One) S M W Sep. D	Race / Ethnicity	Primary Language	Birth Country

Address	City	State	Zip

Home Phone	Work Phone	Cell Phone	Preferred #

Pharmacy: Name Location	E-mail

Preferred Communication (circle one) E-mail Fax Mail Patient Portal Phone Text	*How did you hear about our practice? / What patient referred you?*

Employer	Person responsible for this account

Spouse/Partner's Name Last Middle First	Spouse/Partner's Birth

Emergency Contact	Relationship to Patient	Emergency Contact Ph #

PRIMARY INSURANCE

Primary Insurance Company Name	Street Address
Policy Holder ID #	Group Number

Policy Holder's Name (if other than patient)	Birth Date

Policy Holder's Address (if different than home address)	City	State	Zip

Policy Holder's Phone # (if different than patient phone)	Patient relationship to Policy Holder

SECONDARY INSURANCE

Secondary Insurance Company Name	Street Address
Policy Holder ID #	Group Number

Policy Holder's Name (if other than patient)	Birth Date

Policy Holder's Address (if different than home address)	City	State	Zip

Policy Holder's Phone # (if different than patient phone)	Patient relationship to Policy Holder

Release of information: Others Involved in My Care:
I hereby authorize ***Southdale Ob/Gyn Consultants*** to release my protected health information to the following:

Relationship: Mother____ Father____ Spouse____ Child(ren)____ Other ____

Patient or Representative Signature____ Date: __________________

I hereby authorize ***Southdale Ob/Gyn Consultants*** to furnish information to all insurance carriers and referring physicians concerning my illness and treatment, and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

____________________________ __________________________________ ____________________
Signature **Parent/Guardian Signature** **Date**

My insurer may share my past, current and future health and account records with Southdale OB/GYN Consultants about services I've received from Southdale OB/GYN Consultants and other care providers unrelated to Southdale OB/GYN Consultants. These records may be used by Southdale OB/GYN Consultants as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

____ My insurer may not release any of my identifiable health records from providers unrelated to Southdale OB/GYN Consultants for the purposes described above.

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