Upper Cape Gynecology,P.C.

PATIENT REGISTRATION FORM

We are using **ELECTRONIC MEDICL RECORDS**. Please fill out entire form. Please **PRINT CLEARLY**. Failure to fill out all information may result in your insurance denying payment for your visit, and Pharmacies will be unable to process electronic RX requests. If you have any questions, please ask. Thank you, and welcome to UPPER CAPE GYNECOLOGY, PC.

PATIENT"S DEMOGRAPHIC INFORMATION

Last Name:_______________________First Name:____________________Marital Status:__________

Date of Birth:________________________ Social security#:_____________________________________

Mailing address:____

City:___________________________State:___________Zip Code:_____________________________

Home phone:____________________Cell phone:__________________work Phone:_________________

PERSONAL INFORMATION

Race:_____________________________ethnicity:__________________Language spoken:___________

If you would like to enroll in our patient portal to request appointments, prescriptions, or to communicate with the office via the internet, please provide us with your e-mail:____

Are you employed? (If yes, circle one) FT PT STUDENT Name of Employer?______________________

PATIENT'S INSURANCE INFORMATION

Name of Insurance:____________________________Policy #:___________________Copay$:________

Name of subscriber:___________________________Subscriber DOB:____________________________

Social security # of subscriber:____________________Relationship to subscriber:____________________

EMERGENCY CONTACT INFORMATION

Who shall we notify in the event of an emergency?______________________Relationship:_________________

Address:____Phone:_______________________

Name of Primary Care Physician:____________________Pharmacy Name:__________Location:_____________

CONSENT FOR TREATMENT

I authorize Upper Cape Gynecology to examine and treat me for this and all future appointments I schedule.
I authorize Upper Cape Gynecology to release any and all information necessary to process any insurance billing.
I authorize payment and assignment of payments to Upper Cape Gynecology.
I am responsible for obtaining any referrals required prior to my visit and I am responsible for payment in full for the visit if my insurance declines to pay because such referrals are not in place.
I understand that I am responsible for all charges and deductibles not covered by my insurance company.
I am personally responsible for supplying accurate and current insurance information.
I authorize a copy of this statement to serve as the original.

______________________________________	______________________________________
Signature	Date