OBSTETRICS AND GYNECOLOGY OF WEST ALABAMA, P.C.
PATIENT REGISTRATION FORM

Account Number:_____ Date:_____

Name:(Last)_____(First)_____(Middle)_____

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Home Telephone:_____ Cell/Beeper: _____

Patient Employed By:_____ **Work Telephone:** _____

Race:_____ Marital Status:_____ Social Security Number:_____ Date of Birth:_____

Spouse's Name:_____ Social Security Number:_____

Spouse's Date of Birth:_____

Spouse's Employer:_____ Work Telephone:_____

Nearest Relative
Not Living in Household: _____ Relation: _____ Telephone: _____

Insurance Company: (**Primary**)_____

Policy Holder:_____ Policy Holder Date of Birth:_____

Contract Number:_____ Group Number:_____

Relation of Patient to Policy Holder:_____

InsuranceCompany:(**Secondary**)_____

Policy Holder:_____ Policy Holder Date of Birth:_____

Contract Number:_____ Group Number:_____

Relation of Patient to Policy Holder:_____

Address of Policy Holder/Responsible Party if different from the address of the patient:

_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr._____, for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. PLEASE SIGN:_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr._____, to release any medical or incidental information that may be necessary for either care or in processing applications for financial benefit.
PLEASE SIGN:_____

A photocopy of these assignments shall be valid as the original.

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