

## PATIENT REGISTRATION

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street Address if different \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Work Ph ( ) \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse/Parent Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Ph ( ) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ ECP ( ) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Location/Phone \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policy# \_\_\_\_\_

Group # \_\_\_\_\_ Policyholder's DOB \_\_\_\_\_

SSN \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policy# \_\_\_\_\_

Group # \_\_\_\_\_ Policyholder's DOB \_\_\_\_\_

**BY SIGNING, I GIVE ASHEVILLE OB/GYN PERMISSION TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian (If Minor) \_\_\_\_\_ Date \_\_\_\_\_