PHYSICIANS FOR WOMEN OF GREENSBORO
PATIENT REGISTRATION SHEET

PATIENT INFORMATION:

Name:_____
Last First Middle Maiden

Address:_____
Street Apartment #/Suite

_____
City State Zip County

Home#:_____ Work#:_____ Ext# Cell#:_____

Date of Birth:_____ Social Security#:_____

Sex: M / F Marital Status: S M Sep D W Email address: _____

Race: ❑ Asian ❑ Black/African American ❑ European ❑ Japanese ❑ Korean ❑ White ❑ Other: _____

Ethnicity: ❑ Non Hispanic/Latino ❑ Hispanic/Latino Language: ❑ English ❑ Other:_____

Employed: Y / N Employer:_____ Occupation:_____

Were you referred by a doctor? Y / N If yes, doctor name/practice:_____

PARENT / SPOUSE INFORMATION:

Name:_____
Last First Middle Maiden

Address:_____
Street Apartment #/Suite

_____
City State Zip County

Sex: M / F Marital Status: S M Sep D W Email address: _____

Employed: Y / N Employer:_____ Occupation:_____

Home#:_____ Work#:_____ Ext# Cell#:_____

Date of Birth:_____ Social Security#:_____

EMERGENCY INFORMATION:

Name:_____ Relationship:_____Contact#:_____

Financial Responsibility and Assignment of Insurance Benefits*:* I guarantee payment to Physicians for Women of Greensboro of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits to Physicians for Women of Greensboro for all services rendered. I certify that the information provided by me in regards to my insurance coverage is correct. I will be prepared to present my correct insurance information at every visit.

Consent for Healthcare and Release of Medical Information: I voluntarily consent to healthcare treatment from the physicians and staff at Physicians for Women of Greensboro. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Acknowledgement of Notice of Privacy Practices*:* I have been offered and/or received a copy of the Physicians for Women of Greensboro Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised or additional copy at anytime by writing the office, downloading from the website or requesting one from a Physicians for Women employee.

Acknowledgement of Patient Rights and Responsibilities: I have been offered and/or received a copy of the Physicians for Women Patient Rights and Responsibilities. I am aware that the document may be changed at any time. I may obtain a revised or additional copy at anytime by writing the office, downloading from the website or requesting one from a Physicians for Women employee.

_____ _____
Signature of Patient or Authorized Person **Date**