Registration form

St. Croix OBGYN

Date_____

Patient Information

Name_____ Social Security #_____
Last name First name Middle initial

Physical Address_____ City _____ State_____ Zip Code_____

Mailing address_____ State _____City_____ Zip Code_____
Home Number (___)_____ Cell Phone Number(___)_____
Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ partner for _____ years

Patient employer/ School_____ Occupation_____
Employer/ School Address_____ Employer/ School Phone (__)_____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (___)_____

Primary Insurance

Person responsible for Account_____
Last name First Name Middle initial
Relation to patient_____ Birthdate_____ Social Security#_____
Address (if different from patient's)_____
Phone(___)_____
State _____City_____Zip Code_____
Person responsible Employed by _____ Occupation _____
Insurance Company_____ Contact #_____
Group #_____ Subscriber #_____
Name of other dependents covered under this insurance plan _____

Additional Insurance

Is patient covered by additional insurance? Yes ☐ No ☐
Subscriber name_____ relation to patient_____
Birthdate_____
Address (if different from patient's)_____Phone Number (___)_____
City_____ State_____ Zip code_____
Subscriber Employed By_____ Business Phone (___) _____
Insurance company_____ Social Security # _____
Contract #_____ Group#_____ Subscriber #_____
Names of other dependents covered under this plan_____

Assignment and release

I certify that I, and/or my dependent(s), have insurance coverage with_____and
Name of the Insurance Company (ies)
Assign directly to Dr._____ all insurance benefit, if any otherwise payable to me for service rendered. I understand that I am financially responsible for all charges or not paid by insurance. I authorize the use of my signature on all insurance submission.

The above- named physician may use health care information and may disclosed such information to the above-name insurance company(ies) and their agents for the purpose of obtaining payments for service and determining insurance benefits or the benefits payable for related services this consent will end when current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of parent, Guardian or personal Representative Date

_____ _____
please print name of the patient, parent, Guardian or personal Representative relationship to the patient