



Dedicated to Women  
OB-GYN  
Patient Registration

|                           |
|---------------------------|
| Preferred Pharmacy: _____ |
| Location: _____           |

Patient Account # \_\_\_\_\_ Date \_\_\_\_\_

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

Patient's Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

MAY WE LEAVE A CONFIDENTIAL MESSAGE ON YOUR ANSWERING MACHINE OR VOICE MAIL?  YES  NO IF SO, WHICH NUMBER(S)?  HOME  WORK  CELL

E-Mail Address \_\_\_\_\_ Marital Status:  Single  Married  Widowed  Divorced

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Do you have a living will?  Yes  No

Have you ever been a patient at our practice?  Yes  No If Yes, under what name? \_\_\_\_\_ When? \_\_\_\_\_

Patient's Father's Name \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family Physician \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

PRIMARY MEDICAL INSURANCE

Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Address \_\_\_\_\_  
Street City State Zip

Subscriber's Name \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_ Subscriber's ID# \_\_\_\_\_

Group or Account # \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Subscriber's Social Security # \_\_\_\_\_ Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

SECONDARY MEDICAL INSURANCE

Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Address \_\_\_\_\_  
Street City State Zip

Subscriber's Name \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_ Subscriber's ID# \_\_\_\_\_

Group or Account # \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Subscriber's Social Security # \_\_\_\_\_ Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

I authorize release of any medical information necessary to process this claim and request payment of insurance benefits be paid directly to Dedicated to Women, OB-GYN Associates of Dover, P.A. I also authorize releases of medical information necessary to process disability, loss of income, or any other form requested by myself or my insurance company on my behalf. I further authorize the release of above requested information via FAX transmission.

Signed: \_\_\_\_\_ Date \_\_\_\_\_ Witness: \_\_\_\_\_ Date \_\_\_\_\_  
Patient's Signature Date Witness Signature Date

\*\*\* I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE. \*\*\*

In the event that any account is placed with a third party for collection, I agree to pay the collection agency fee of 35% in addition to the balance owed on the account.

Signed: \_\_\_\_\_ Date \_\_\_\_\_ Witness: \_\_\_\_\_ Date \_\_\_\_\_  
Patient's Signature Date Witness Signature Date