Women's Health Alliance

Total Care, Total Trust... For Life

www.womenshealthalliance.com

Patient Registration Form

Name (First) _____ (MI) _____ (Last) _____ Age _____

Street Address _____ Unit or apt. # _____

City _____ State _____ Zip Code _____

Cell Phone (_____) _____ Home or Work (_____) _____
Please Circle One

Date of Birth _____ Social Security Number _____

Email _____ Marital Status (Circle only one) S M D W

Employer _____ Occupation _____

Emergency Contact Name _____ Phone (_____) _____

Name of Insurance Company _____

Policy Holder is: ❑ Self ❑ Spouse* ❑ Parent/Guardian*

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Member ID # _____ Insurance Plan's Group # _____

Policy Holder Social Security # _____

Policy Holder's Home Address _____ _____

Policy Holder's Employer _____ Work # _____

Referred by: ❑ My Managed Care Directory ❑ AT&T Yellow Pages ❑ 1-800-For-Baylor

❑ Patient _____ ❑ Physician _____

❑ Friend, not a patient ❑ Web Site _____

❑ Other _____

Insurance is a method of payment for services rendered by your physician. It is your responsibility to pay any deductibles, co-pay, or any other balance not paid by your insurance company. Women's Health Alliance does not recognize, accept or file secondary insurance. Reimbursement from your secondary insurance carrier is your responsibility. You authorize disclosure of your medical records, if needed, to assist reimbursement from the insurance company. I hereby assign all medical and/or surgical benefits to my physician and/or his designated associate. A photocopy or fax copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether paid or not paid by said third party or other insurance carrier.

_____ _____

Patient Signature Date Responsible Party's Signature Date