HAMPTON ROADS
OBSTETRICS & GYNECOLOGY
a Division of Mid-Atlantic Women's Care, PLC

PATIENT REGISTRATION FORM

*Please fill out all the information below, if this is your first visit, fill out the **left side only.***

_____ _____ _____ Single/Mar/Div/Wid *Today's date* *Date of birth* *Age* *Marital Status (circle)*	_____ _____ ____ Single/Mar/Div/Wid *Date of **Revised** Information* *Date of birth* *Age* *Marital Status (circle)*
Your name (first, M.I., last)	*Your name (first, M.I., last)*
Your Address (Street Address, Apartment Number)	*Your Address (Street Address, Apartment Number)*
City *State* *Zip*	*City* *State* *Zip*
(_____)_____(_____)_____(_____)_____ *Home Phone* *Work Phone* *Cell Phone*	(_____)_____(_____)_____(_____)_____ *Home Phone* *Work Phone* *Cell Phone*
Social Security Number *Your Employer*	*New Employer*

INSURANCE INFORMATION

Primary Insurance Company **(give card to receptionist)**

Address of Insurance Co. (City, State, Zip)

Member (your) ID# Group#

Policy Holder Info/Responsible Party Info (If not you)

Their name *Their SSN* *Their DOB*

Their place of employment *Their relationship to you*

Secondary Insurance Company (Give card to receptionist)

Address of Insurance Company (City, State, Zip)

Member (your) ID Number *Group #*

Secondary Policy Holder *Their SSN* *Their DOB*

INSURANCE UPDATE

New Primary Insurance Company **(give card to receptionist)**

Address of Insurance Co. (City, State, Zip)

Member (your) ID# Group#

Policy Holder Info/Responsible Party Info (If not you)

Their name *Their SSN* *Their DOB*

Their place of employment *Their relationship to you*

Secondary Insurance Company (Give card to receptionist)

Address of Insurance Company (City, State, Zip)

_Member (your) ID Number *Group #*

Secondary Policy Holder *Their SSN* *Their DOB*

EMERGENCY CONTACT *(List someone who lives at a different residence than yours)*

Name of Emergency Contact Relationship to you Address of Emergency contact Phone number

Please read and sign below. Read these terms carefully.

- I understand it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by insurance.
- I agree to pay my portion of charges for office visits at the time of each visit.
- I understand that if this account is assigned to a collection agency, the costs of the collections will be charged to me.
- I understand that if I fail to cancel my appointment more than 24 hours in advance, I will be charged a cancellation fee.
- I authorize the release of any information necessary to determine payment or collect reimbursement on any claim.
- I request that payment of benefits be made on my behalf and assign those benefits including Medicare, private insurance, and other health plans to Hampton roads OB/GYN Inc.
- I understand that if this account is assigned to a collection agency, or an attorney, the fees will be charged to me.

SIGNED: _____ **DATE:** _____