Venus Ob-Gyn

REGISTRATION FORM

PATIENT INFORMATION

Patient's name:	Date of Birth: / /	Social Security no.:	Marital status (circle one) Single / Mar / Div / Sep / Wid

How did you hear about our office:

□ Friend □ Insurance □ Internet □ Primary Care Physician _____ □ Other _____

Address	City:	State:	ZIP Code:

Home Phone: ( )	Cell Phone: ( )	Email Address:

Primary care Physician	Address	Phone number
Preferred pharmacy	Address	Phone number
Occupation:	Employer:	Employer phone no.: ( )

Spouse's Name:	Spouse DOB: / /	Spouse's Employer:

Can the office leave a message on your voicemail? _____Yes _____No _____ Initials

INSURANCE INFORMATION

(Please give your insurance card to the receptionist) *Venus OB-GYN will file your visit with your insurance company but it is not a guarantee of benefits. Any balance not covered by your insurance company is your responsibility.

Primary insurance

Plan name	I.D. number	Group number
Policy holder	Date of Birth / /	Social security number

Employer:	Policy holder address:	Policy holder phone no.: ( )
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Other	

Secondary insurance

Plan name	I.D. number	Group number
Policy holder	Date of Birth / /	Social security number

Employer:	Policy holder address:	Policy holder phone no.: ( )
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone : ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Venus OB-GYN or insurance company to release any information required to process my claims. I also understand my right to file a complaint with my insurance carrier. I also authorize Venus OB-GYN to evaluate and treat me for any condition I present with. I understand that any unpaid balance could generate a late fee and be turned over to an outside collection agency.

Patient/Guardian signature *Date*