Raleigh Gynecology & Wellness, PA

# PATIENT REGISTRATION FORM

Chart # _____

Date: _____ Social Security No. _____

Name: _____ Maiden Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Business Phone: _____

Birth Date: _____ Birth Place: _____ Marital Status: _____

Education: _____ Occupation: _____

Employer: _____ Length of Employment: _____

Name of Spouse / Parent: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

**Children**

Name: _____ Age: _____ | Name: _____ Age: _____

Emergency Notification other than spouse: Name: _____ Phone No. _____

Referring Physician: _____ Last Physical Exam: _____

Primary Insurance Co. _____

Subscriber Name: _____

Sex: _____ Birthdate:_____ Social Security No._____

Relationship to Patient: ___SELF ___SPOUSE ___PARENT

Effective Date: _____ First ID No. _____ Second ID No. _____

Secondary Insurance Co. _____

Subscriber Name: _____

Sex: _____ Birthdate:_____ Social Security No._____

Relationship to Patient: ___SELF ___SPOUSE ___PARENT

Effective Date: _____ First ID No. _____ Second ID No. _____

PAYMENT AGREEMENT

I AGREE TO PAY WILLIAMS, BENAVIDES & MARSTON, M.D., P,A. FOR ANY SERVICES NOT COVERED BY MY INSURANCE COMPANY. I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION TO THE ABOVE INSURANCE CO. AND AUTHORIZE PAYMENT DIRECTLY TO WILLIAMS, BENAVIDES & MARSTON, M.D., P.A.

I UNDERSTAND THERE WILL BE A $25.00 CHARGE FOR ANY MISSED APPOINTMENT WITHOUT 48 HOURS NOTICE.

SIGNATURE: _____ DATE: _____