

Advanced Women's Care Center, S.C.

Patient Registration Information

Last Name _____ First _____ M.I. _____

Address _____ Apt/Ste _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Date of Birth _____ Age _____ Social Security# _____

Occupation _____ Student: Full-time _____ Part-time _____

Employer _____

Address _____

Please circle one: Married Single Divorced Widowed Partner Minor

Spouse/Parent/Partner: Name _____ Phone _____

Emergency Contact: Name _____ Phone _____

REFERRING PHYSICIAN/ PCP _____ **PHONE #** _____

REFERRED BY: _____ **Relationship:** _____

INSURANCE INFORMATION

Primary Insurance Company _____

Carrier's Name _____ ID # _____ Group # _____

Secondary Insurance Company _____

Carrier's Name _____ ID # _____ Group # _____

* If the above insurance is **through a spouse, parent, or partner** please fill in the information below:

Last Name _____ First _____ M.I. _____

Date of Birth _____ Social Security # _____

Employer _____

I hereby authorize Advanced Women's Care Center, S.C. and its agents to release to, and discuss with my insurance company, family physician, information related to treatment by Advanced Women's Care Center, S.C. I authorize the benefits be paid directly to them. I understand that charges are not contingent on any insurance payment from my insurance company, and that I am responsible for payment of **any unpaid balance**. It is my responsibility to notify my insurance company and this office for any surgical procedures or tests if any pre-certification is required. In the event I am to change the above insurance company(s), it is my responsibility to notify Advanced Women's Care Center, S.C. **prior** to my next appointment.

Signature of patient/guardian _____ **Date** _____