Dr. Katherine Boyd - Aquia Ward, RN, WHNP-BC

PATIENT REGISTRATION INFORMATION

Where did you hear about us, or were you referred? ______________________________

Social Security #:______________________ Driver's License #:__________________ State: __________

Name: ______________________ ______________________ __________
LAST FIRST MI

Date of Birth ________/________/________ Age: __________ Race: W B H O Marital Status: S M D W O

Address: ______________________ __________ __________ __________
MAILING ADRESS CITY ST ZIP

(_________) ______________________ (_________)______________________
HOME PHONE# CELL PHONE #

Employer's Name: ______________________ Occupation: ______________________

Employer's Address: ______________________ __________ __________ __________
STREET ADDRESS CITY ST ZIP

(_________)______________________ FULL-TIME / PART-TIME
WORK PHONE

Emergency Contacts: ______________________ (_________) ______________________
NAME PHONE NUMBER

______________________ (_________) ______________________
NAME PHONE NUMBER

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient Relationship to Responsible Party: Self Spouse Child Other:__________________

Name: ______________________ ______________________ __________
Last First MI

Date of Birth: ______/______/______ Age: ______________ Marital Status: S M D W O

Address: ______________________ __________ __________ __________
Mailing Address City ST Zip

Employer's Name: ______________________ Work Phone: (_________) ______________________

PRIMARY INSURANCE

Insurance Company: ______________________________ (_____) ______________________
Phone #

Insured: ______________________________ ______________________ ________
Last Name First Name MI

Date of Birth: ______/______/______ Sex: F_____ M ______ Social Security #: ____________________

Patient Relationship to Insured Party: Self Spouse Child Other: ____________________

Employer's Name: ______________________ Insured ID#:____________________ Group#:____________

SECONDARY INSURANCE

Insurance Company: ______________________________ (_____) ______________________
Phone #

Insured: ______________________________ ______________________ ________
Last Name First Name MI

Date of Birth: ______/______/______ Sex: F_____ M ______ Social Security #: ____________________

Patient Relationship to Insured Party: Self Spouse Child Other: ____________________

Employer's Name: ______________________ Insured ID#:____________________ Group#:____________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

PLEASE READ: All charges are due at the time of service. If surgery is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to surgery.

I hereby assign, transfer and set over to A Woman's View Women's Healthcare all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills not paid by my insurance company, or any balance due after payments by my insurance company.

______________________________ ______________________

Patient Signature Date