North Scottsdale Women's Care, P.C
Obstetrics & Gynecology
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ACCT. #_____

- ☐ NEW PATIENT
- ☐ NEW OB
- ☐ NAME CHANGE
- ☐ ADDRESS CHANGE
- ☐ INS. CHANGE
- ☐ UPDATE

Most insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign the registration form on an annual basis. Please complete this form prior to your appointment and bring it with you. THANK YOU

PATIENT INFORMATION

Patient's Legal Name _____ (Last / First / Middle) Birth Date _____ S.S. # _____

Address _____ (Street / City / Zip) Home Phone # (____) _____ (Area Code) Marital Status _____

Employer's Name _____ Occupation (Indicate if Student) _____

Employer's Address _____ (Street / City/St / Zip) Business Phone # (____)_____ (Area Code)

Patient's Primary Doctor _____ (Name / Street / City/St Zip) Drs. Phone # (____)_____ (Area Code)

Name, Address of Nearest Friend or Relative _____ Phone (____) _____ (Area Code) Relationship _____

PARENT/SPOUSE INFORMATION

Parent /Spouse Name _____ (Last / First / Middle) Birth Date _____ S.S. # _____

Address _____ (Street / City / Zip) Home Phone # (____) _____ (Area Code) Home Phone # (____) _____ (Area Code)

Employer _____ Employer's Address _____ (Street / City / Zip)

PRIMARY INSURANCE

Ins. Company Name_____ Address _____ Phone # _____

ID#/Policy # _____ Group # _____ Effective Date _____

Policy Holder's Name_____ Relationship to PT. _____ Birthdate_____

Policy Holder's Address _____ Home Phone _____

Policy Holder's Employer_____ Business Phone _____

SECONDARY INSURANCE

Other Insurance Co. _____ Address _____ Phone_____

Other Insured (If other than patient)_____ Address _____ Phone_____

Birth Date_____ Relationship to Patient _____ ID #/Policy # _____ Group # _____

Other Insured's Employer _____ Address _____ Phone # _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be Responsible for any collection and/or legal fees.
I have read and understand the office policy and procedures.

* _____ _____

Responsible Party Signature Date