

ARLINGTON OB-GYN P.C  
Patient Registration Form  
Please Print

Date \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient \_\_\_\_\_

Last Name

First Name

Initial

Responsible Party (if patient is a minor) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex  M  F

Age \_\_\_\_\_

Birth Date \_\_\_\_\_  Single  Married  Divorced

Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Patient Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

With whom may we share information about your account? Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

With whom may we share your medical records? Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Do you have Medical Insurance? \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of Secondary Insurance Company (if any) \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Medicare # \_\_\_\_\_  Medicaid # \_\_\_\_\_

How were you referred to our practice?  Friend/Relative, if so, name: \_\_\_\_\_

Yellow Pages  Physician, if so, name: \_\_\_\_\_  Receiving Mail

Newspaper  Hospital referral  Other? \_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other

commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have received notice of this organization's privacy policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Information Update