PATIENT REGISTRATION & HEALTH QUESTIONNAIRE-PLEASE PRINT
***This form is to be completed annually**

NAME_____**NICK NAME**_____**DATE OF BIRTH**_____

MARITAL STATUS: (circle one) M S D W EMAIL:_____ **REFERRED BY:**_____

ADDRESS:_____**APT#**_____**CITY.**_____**ST.**_____**ZIP**_____

PHONE: HOME_____**WORK**_____**EMPLOYER**_____

CELL PHONE_____**SS#**_____

SPOUSE'S NAME_____**DATE OF BIRTH**_____**SS#**_____

EMPLOYER_____**CELL PHONE**_____ **WORK PHONE**_____

IF UNDER 18-PARENT/GUARDIAN_____

EMERGENCY CONTACT (other than spouse)_____**PHONE**_____

PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITIES_____

PHARMACY PHONE # AND ADDRESS_____

DO YOU GIVE US PERMISSION TO RECEIVE HISTORY FROM PHARMACY & SEND PRESCRIPTIONS TO THEM? _____

PRIMARY CARE PHYSICIAN _____

INSURANCE & BILLING INFORMATION

PRIMARY INSURANCE CO:_____**GROUP #**_____**ID#**_____

NAME OF INSURED_____**RELATIONSHIP TO PT**_____**DATE OF BIRTH**_____**SS#**_____

SECONDARY INSURANCE CO:_____**GROUP #**_____**ID#**_____

NAME OF INSURED_____**RELATIONSHIP TO PT**_____**DATE OF BIRTH**_____**SS#**_____

NAME & ADDRESS OF PERSON RESPONSIBLE FOR BILL_____

_____

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and primary care physician and to my insurance co.
I allow fax transmittal of my medical records, if necessary
I acknowledge full financial responsibility for services rendered by The Women's Group of Gwinnett, P.C. There will be a $25.00 returned check fee.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to the named provider.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.
Medical records consist of confidential information relating to your health. It is the policy of The Women's Group of Gwinnett, P.C. not to release medical records without the patient's prior written consent. I understand that any request for release of such medical records must be in writing at the time of such request.

Signature_____**Date**_____

PARENT/GUARDIAN (under 18)_____ _____

Printed **Signature**