

Patient Registration



Last Name		First Name		MI
Street Address				
City, State, Zip			Social Security Number	
Home Phone ()	Work Phone ()	Cell Phone ()	Marital Status S M W D SEP	
Date of Birth	Age	Primary Care Physician		
Occupation/Employer		Referred By:		
Spouse's Name		Spouse's SSN	Spouse's Date of Birth	
Spouse's Occupation/Employer		Spouse's Work Phone ()		
Emergency Contact	Name	Phone	Address ()	Relationship
If necessary, may we contact you via email?		Yes	No	If yes, please provide email address
Billing/Insurance Information				
Primary Insurance Company Name		Claims Mailing Address		
Name of Insured	Relationship to Patient Self Spouse Parent Other		Policy Effective Date	
Policy ID Number	Group Number			
Secondary Insurance Company Name		Claims Mailing Address		
Name of Insured	Relationship to Patient Self Spouse Parent Other		Policy Effective Date	
Policy ID Number	Group Number			
Release of Information/Assignment of Benefits				
<p>I authorize Women's Health Specialists of St. Louis, LLC to release to my insurance carrier(s), any information required for payment for all services for one year from the date below, unless otherwise specifically revoked. I request and authorize that my insurer(s) make payment directly to Women's Health Specialists of St. Louis, LLC for services rendered. I understand that I am financially responsible for any charges or balance not covered by my insurance. In the event my account is turned out to collections, I understand that any additional fees associated with this are my sole responsibility.</p> <p>A photocopy of this assignment shall be valid as the original.</p>				
Signature _____		Date _____		
Parent/Guardian _____ (please print)		Date _____		
Office Use Only	New	Established		