WOMEN'S MEDICAL GROUP OF UPLAND, INC.

600 N. Mountain Ave., Suite A104 Upland, CA. 91786

(909) 931-1033 FAX (909) 981-8976

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age: Sex: ❑ M ❑ F

Street address:	Social Security #:	Home phone #: ( )

City: State: ZIP Code:	P.O. box:

Occupation:	Employer & Address:	Employer phone #: ( )

Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Mailing Address (if different):	Home phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary insurance carrier:					
Subscriber's name:	Subscriber's S.S. # (Req.):	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance whether or not paid by my insurance. I also authorize Women's Medical Group of Upland or insurance company to release any information required to process my claims.

_____

Patient/Guardian signature *Date*

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACEY PRACTICES

I acknowledge that a copy of the current Notice of Privacy Practices is posted in the reception area. I agree to read this notice at my convenience.

Print Name: _____

Signature: _____

Date: _____

If not signed by patient please indicate:

Relationship:

_____ Parent / Guardian

_____ Beneficiary or Personal Representative

Patient Name: _____

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Please be advised that any lab fees and/ or bills that you may receive from the laboratory where your lab results are sent **are not** the responsibility of this office. Please contact your insurance if you are not sure what is covered by your insurance carrier.

Please sign that you have received this notice.

_____ Date: _____

Thank you,

Women's Medical Group