Welcome to Montgomery Women's Health Associates, P.C. • **Patient Registration**

•• Everyone must complete entire form before being seen

New Patient to the Practice? ❑ Yes ❑ No

Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home telephone # ( ) _____ - _____

Work telephone # ( ) _____ - _____

Cell phone # ( ) _____ - _____

Email _____

Arrival time: _____

Appointment Time: _____

Check one:

❑ Dr. Jehle	❑ Lab Only
❑ Dr. McClinton	❑ Ultrasound
❑ Dr. Dockery	❑ Procedure
❑ Dr. Miller	❑ Nurse
❑ Dr. Jones	❑ Study Patient

Preferred Communication: ❑ Cell ❑ Home ❑ Text ❑ Email

Marital Status: M S W D

Spouse / Insured

Name_____ DOB_____

Please give receptionist ins. card & Drivers License or Picture I.D. to verify info.

Date of Birth: ____ / ____ / ____ SS #: _____ Preferred Pharmacy: _____

As our patient, we want to provide you the best care possible. There may be certain routine services that we feel are necessary for the maintenance of good health which are not covered by Medicare, Blue Cross, or any other insurance. You will be expected to pay for those services in full. Be assured that we order only tests that are necessary for your treatment and care. Also, if your insurance requires an as60024uthorization or referral from your primary care practitioner, it is your responsibility to obtain this prior to your appointment. In the event no referral is obtained you will be responsible for the services not covered.

Co-payments are due at time of service.

I have read your policy and agree to pay for services not covered by my insurance as indicated by my signature below.

Signature _____ Date _____