

# 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 \_\_\_\_\_

Preferred Communication:  Cell  Home  Text  Email Spouse / Insured

Marital Status:        M        S        W        D                      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 as60024authorization 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 \_\_\_\_\_

Arrival time: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

### Check one:

- |  |  |
|--|--|
| <input type="checkbox"/> Dr. Jehle     | <input type="checkbox"/> Lab Only      |
| <input type="checkbox"/> Dr. McClinton | <input type="checkbox"/> Ultrasound    |
| <input type="checkbox"/> Dr. Dockery   | <input type="checkbox"/> Procedure     |
| <input type="checkbox"/> Dr. Miller    | <input type="checkbox"/> Nurse         |
| <input type="checkbox"/> Dr. Jones     | <input type="checkbox"/> Study Patient |