# PHYSICIANS FOR WOMEN OF GREENSBORO
# PATIENT REGISTRATION SHEET

***PATIENT INFORMATION:***

Name:_____
Last First Middle Maiden

Address:_____
Street Apartment #/Suite

_____
City State Zip County

Sex: M / F Marital Status: S M Sep D W Email address:_____

Employed: Y / N Employer:_____Occupation:_____

Home#:_____ Work#:_____ Ext# Cell#:_____

Date of Birth:_____ Social Security#:_____

Were you referred by a doctor? Y / N If yes, doctor name/practice:_____

***PARENT / SPOUSE INFORMATION:***

Name:_____
Last First Middle Maiden

Address:_____
Street

_____
City State Zip County

Sex: M / F Marital Status: S M Sep D W Email address:_____

Employed: Y / N Employer:_____Occupation:_____

Home#:_____ Work#:_____ Cell#:_____

Date of Birth:_____ Social Security#:_____

***EMERGENCY INFORMATION:***

Name:_____Relationship_____Contact#:_____

***Financial Responsibility and Assignment of Insurance Benefits:*** I guarantee payment to Physicians for Women of Greensboro of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits to Physicians for Women of Greensboro for all services rendered. I certify that the information provided by me in regards to my insurance coverage is correct. I will be prepared to present my correct insurance information at every visit.

***Consent for Healthcare and Release of Medical Information:*** I voluntarily consent to healthcare treatment from the physicians and staff at Physicians for Women of Greensboro. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

***Acknowledgement of Notice of Privacy Practices:*** I have been offered and/or received a copy of the Piedmont Healthcare for Women Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised or additional copy at anytime by writing the office or requesting one from a Physicians for Women employee.

_____ _____

**Signature of Patient or Authorized Person** **Date**