



Women's Health Alliance

Total Care, Total Trust... For Life

www.womenshealthalliance.com

Patient Registration Form

Name (First) _____ (MI) _____ (Last) _____ Age _____

Street Address _____ Unit or apt. # _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Social Security Number _____

Date of Birth _____ Marital Status (Circle only one) S M D W

Employer _____ Occupation _____

Email _____

Emergency Contact Name _____ Phone (_____) _____

Primary Insurance Company _____

Policy Holder Self Spouse* Parent/Guardian* Policy Holder Name _____

Policy Holder Phone (_____) _____ Policy Holder Date of Birth _____

Policy Holder Address _____

Referred by: My Managed Care Directory AT&T Yellow Pages 1-800-For-Baylor

Patient _____ Physician _____

Friend, not a patient Web Site _____

If you are on Medicare, please present your supplemental insurance card at check-in.

Insurance is a method of payment for services rendered by your physician. It is your responsibility to pay any deductibles, co-pay, or any other balance not paid by your insurance company. Women's Health Alliance does not recognize, accept or file secondary insurance (except Medicare). Reimbursement from your secondary insurance carrier is your responsibility. You authorize disclosure of your medical records, if needed, to assist reimbursement from the insurance company. I hereby assign all medical and/or surgical benefits to my physician and/or his designated associate. A photocopy or fax copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether paid or not paid by said third party or other insurance carrier.

Patient Signature

Date

Responsible Party's Signature

Date