Practice Name: Wade Dickinson, M.D.

VALLEY WOMENS HEALTHCARE MEDICAL GROUP

PATIENT REGISTRATION FORM (Please print)

Patient Demographics

First Name: _____ **SSN:** ___ — ___ — ___

Last Name: _____ **Age:** Yrs _____ Mo _____

Date of Birth: _____ **Sex:** Male Female

Home Address _____ **Marital Status:** Single Married Widowed Divorced

City, State, Zip _____ **Employer:** _____

Home Phone: _____ **Occupation:** _____

Cell Phone: _____ **Work Address:** _____

Email: _____ **Work Phone:** _____

Emergency Contact Name & Relation: **Emergency Phone (diff. than home):**

Responsible Party Info (if other than patient)

First Name: _____ **SSN:** ___ — ___ — ___

Last Name: _____ **Age:** Yrs _____ Mo _____

Date of Birth: _____ **Sex:** Male Female

Home Address _____ **Employer:** _____

City, State, Zip _____ **Occupation:** _____

Home Phone: _____ **Work Address:** _____

Cell Phone: _____ **Work Phone:** _____

Relation to Patient:

Insurance Information

Primary Insurance Name: _____ **Ins. Card Provided:** Yes No

Subscriber Name: _____ **Subscriber ID:** _____

Insurance Address: _____ **Group ID:** _____

Subscriber DOB: **PCP Assigned:**

Secondary Insurance Name: _____ **Ins. Card Provided:** Yes No

Subscriber Name: _____ **Subscriber ID:** _____

Insurance Address: _____ **Group ID:** _____

Subscriber DOB: **PCP Assigned:**

Consent for Treatment

I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment, until I revoke this acknowledgment in writing.

Financial Respons.

I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person(s) of financial and medical information concerning care, treatments, and charges as may be required to complete all claims for benefits. I understand that I am financially responsible to the above-named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. I am aware all co-payment amounts are due at the time of visit and must be paid prior to services rendered. I am aware that I am personally responsible for any and all charges for services not covered under my insurance plan, or deductibles/co-insurance amounts that are due prior to active coverage. I understand that I am financially responsible for any and all costs related to laboratory tests, as part of my medical care, that are rendered and not covered by my current insurance plan. I understand a bill will be issued to me for payment on any unpaid/uncovered services.

Notice of Privacy Practice

By signing this form I acknowledge I have been given the opportunity to read the Notice of Privacy Practices Policy in its entirety, and been offered a copy of the document. Furthermore, I recognize and understand my rights and the ways my protected health information may or may not be used and/or disclosed in relation to my healthcare and services received.

How did you hear about our office?	Health Fair	Friend or Family	Insurance Assignment	Online Search	Referral	If Referred, who were you referred by? _____
Circle your preferred method of contact	Text	Voicecall	Email	Post Mail		

Patient/Responsible Party Signature _____ **Date** _____