Women's Cancer &Wellness Institute

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Patient Registration Form

Patient's name: _____ Social Security #: _____

Date of birth: _____ Primary phone #: _____Secondary phone #: _____

☐ Male ☐ Female Email address: (print clearly)

_____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Declined ☐ Other: _____
Race: ☐Caucasian ☐African American ☐Asian ☐ Hispanic ☐ Declined ☐ Other: _____

Mailing address: _____

City, State: _____ Zip: _____

Patient's employer: _____Work phone #: _____

☐ I have no insurance, I am self-insured
Primary Insurance: _____ Policy Number:_____
Group Number: _____ Policy Holder Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder Name: _____

Emergency contact name: _____ Phone number w/area code: _____
Relationship to patient: _____ DOB: _____

Preferred Pharmacy: _____ Phone Number: _____

Primary Care Doctor: _____ Phone #: _____

By signing this form below, I authorize all services to be billed to my insurance company for payment and for all benefits to be paid directly to Women's Cancer and Wellness Institute. I understand and agree if my account, or the account of the individual I am guaranteeing, is placed with a collection agency and/or attorney for collection, I agree to pay the balance owed in addition to any and all costs of collection, including within limitation, an attorney fee equal to one-third (1/3) of outstanding balance and all other costs associated with collection. If you fail to give us all active insurance policies, then you may be responsible for any charges denied for timely filing. I understand there is a $50 returned check fee.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Date