Partners in Obstetrics & Gynecology
a division of Southern New England Healthcare for Women, LLC
PATIENT REGISTRATION

Last Name: _____ First Name: _____ Date of Birth _____

Maiden Name: _____ Marital Status: ___S ___M ___D ___W Social Security # _____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred method of contact: (please circle one) Home # Work # Cell #

Language: ☐ English - Spanish ☐ - Other _____ Race: _____ Ethnicity: _____

Employer: _____ Occupation: _____ Phone: _____

Partner's Name: _____ Date of Birth: _____ Phone: _____

PRIMARY CARE PHYSICIAN _____ PCP PHONE: _____
PCP Address _____ City _____ State _____ Zip _____

PHARMACY _____ PHARMACY PHONE _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

INSURANCE PLAN NAME _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Policy Holder Name _____ Relationship _____

Policy Holder Date of Birth _____

Policy # _____ Group # _____

IF YOU HAVE TWO INSURANCES, PLEASE COMPLETE THE FOLLOWING:
SECONDARY INSURANCE PLAN NAME _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Policy Holder Name _____ Relationship _____

Policy Holder Date of Birth _____

Policy # _____ Group # _____

I hereby authorize release of information necessary to file claim with my insurance company and assign benefits to Southern New England Healthcare for Women, LLC (SNEHW). I agree that I will pay any collection or attorney fees and costs incurred in collection of my account by SNEHW. I understand that I am financially responsible all charges not covered by my insurance, including those resulting from my failure to provide the practice with current/updated insurance information or obtain the necessary referral and/or other authorization from my primary care and/or referring physician when required. A copy of this signature is a valid original.

I also acknowledge that the practice has made the Health Insurance Portability and Accountability Act (HIPPA) notice effective April 13, 2003 available to me on the date indicated below.

Signature _____ Date _____