embodywellness
OBSTETRICS • GYNECOLOGY

REGISTRATION FORM

(Please Print)

Preferred Pharmacy: (include address)	Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security number:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street address:		Cell phone number: ( )	Home phone number: ( )		
P.O. BOX:	City:	State:	ZIP Code:		
Occupation:	Employer:		Employer phone no.: ( )		
How did you hear about us??? (please check box):	☐ Dr.	☐ Insurance Plan	☐ Hospital		
☐ Family	☐ Friend	☐ Close to home or work	☐ Other		
Language[s] (please check box):	☐ English	☐ Spanish	☐ Other:		
Race (please check box):	☐ White	☐ Black or African American	☐ Asian	☐ American Indian	

INSURANCE INFORMATION

(Please give your insurance card[s] to the receptionist)

Is this patient covered by insurance? ☐ Yes ☐ No					
Please indicate primary insurance	☐ Aetna(not a provider)	☐ Anthem BC/BS	☐ Cigna	☐ Caresource	☐ United Health Care
☐ Molina (not a provider)	☐ Medicaid	☐ Medicare	☐ Other:		

Subscriber's name (if different than above):	Subscriber's S.S. number:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Embody Wellness or insurance company to release any information required to process my claims.

Patient signature *Date*