Client Registration Information **Date ___/___/___**

Name _____
(Last) (First) (Middle)
Preferred Name (if different) _____

Responsible Party Name (if different) _____
(Last) (First) (Middle)
Mailing Address_____Apt#___City_____State___Zip_____
Permanent Address (if different)_____ Apt#___City_____State___Zip_____

Home Phone _____Work Phone _____ Date of Birth ___/___/___ Age___ Sex/Gender_____

Soc. Sec. # _____- ____- _____ Resp. Party Soc. Sec. # _____-____-_____ Resp. Party Relationship____

Employment/School Status (circle one) Employed Unemployed F/T Student P/T Student
Employer/School_____ Phone_____
(Name) (Address) (All information is confidential and no one will be contacted)
Marital/Partner Status (circle one) Married Single Long Term Relationship
Partner or Nearest Relative_____Phone_____
(Name) (Address)
In Case of Emergency Contact_____ Phone_____
(Name) (Address)

Insurance Information

Primary Insurance _____
Address _____
Phone _____
Policy Holder Name _____
Relation to Client _____ Copay_____
Employer _____
Sex/Gender_____ Date of Birth ___/____/___
Policy # _____ Group # _____

Secondary Insurance_____
Address _____
Phone _____
Policy Holder Name _____
Relation to Client _____ Copay_____
Employer _____
Sex/Gender _____ Date of Birth ___/___/___
Policy #_____ Group#_____

Uninsured/Self-pay

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Birth and Women's Health Center to release any medical information requested by insurance companies whom I have coverage or any public agency which may be assisting in payment of my medical care.

AUTHORIZTION TO PAY: I hereby authorize payment directly to Birth and Women's Health Center for surgical and/or medical benefit, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

Signed (client or responsible party if applicable) _____