ASHEVILLE WOMEN'S MEDICAL CENTER

YOUR CENTER OF EXCELLENCE FOR PERSONALIZED HEALTHCARE

REGISTRATION FORM

Today's date	Chart #	Social Security #

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial	Address

City:	State	Zip Code	Home #	Work #	Cell #

Date of Birth / /	Employer/School	Employer Address	Employed/Student ❑ FT ❑ PT ❑ Self ❑ Military

Email Address (if applicable)	Referred to AWMC by Dr.

Primary Care Physician	**Primary Care Phone #**	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

We must have this information in order to file your insurance

Primary Insurance Company Name:

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	Group #/ ID #	Policy #	Co-payment $

Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Subscriber's Employer	Employer Address	Employer Phone #

Secondary Insurance Company Name: (if applicable)

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	Group #/ ID #	Policy #	Co-payment $

Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Subscriber's Employer	Employer Address	Employer Phone #

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Home phone #	Work phone #

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Asheville Women's Medical Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. **As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility.**

_____ _____

Patient/Guardian signature *Date*