ASHEVILLE WOMEN'S MEDICAL CENTER

REGISTRATION FORM

(Please Print)

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	**Employed** ☐ FT ☐ PT ☐ Self ☐ Military	**Student** ☐FT ☐ PT	**Preferred Language** ☐ Spanish ☐ Russian ☐ Sign Language	☐ English ☐ Other ☐ Decline

Email Address (if applicable)	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Other ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ More than One Race ☐ Decline

Primary Care Physician	**Primary Care Phone #**	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline	**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. #	Subsriber'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. #	Subsriber'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 _____