

**Patient Information** Please print and complete all information.

Doctor: \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
(last name) (first name) (middle initial)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Driver License Number: \_\_\_\_\_

Responsible Party (if patient is under 18 years of age): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Pager: (\_\_\_\_) \_\_\_\_\_

Marital Status:  Single  Married  Legally Separated  Divorced  Widowed  Other \_\_\_\_\_

Employment Status:  Full Time  Part Time  Not Employed  Self Employed

Retired  Active Duty  Full Time Student  Part Time Student

Primary Care Physician: \_\_\_\_\_ Primary Care Physician Phone Number: \_\_\_\_\_  
(last name) (first name)

Name of Referring Physician: \_\_\_\_\_ Referring Physician Phone Number: \_\_\_\_\_  
(last name) (first name)

In case of Emergency, whom should we notify? \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to emergency contact? \_\_\_\_\_

Do you (patient) have a living will (advance directive?)  Yes  No How did you hear of our office? \_\_\_\_\_

**Insurance Information** Complete entire section and provide a copy of your insurance card(s) to registration personnel.

Primary Insurance policy: \_\_\_\_\_ I have no insurance

Subscribers Name: \_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_  
(last name) (first name) (middle initial)

Relationship to Subscriber:  Self  Spouse  Parent  Other: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscribers Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_/\_\_\_\_/\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Policy or Identification Number: \_\_\_\_\_ Group Number \_\_\_\_\_

Claims mailing address: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Secondary Insurance policy (If applicable): \_\_\_\_\_ I have no other insurance

Subscribers Name: \_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_  
(last name) (first name) (middle initial)

Relationship to Subscriber:  Self  Spouse  Parent  Other: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscribers Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_/\_\_\_\_/\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Policy or Identification Number: \_\_\_\_\_ Group Number \_\_\_\_\_

Claims mailing address: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Kansas City Women's Clinic, P.A. to file insurance and assign benefits directly payable, to Kansas City Women's Clinic, P.A.. I authorize Kansas City Women's Clinic, P.A. to release any medical or incidental information that may be necessary for either medical care or processing for financial benefits. I understand insurance claims are filed as a courtesy. All balances (including balances for failure to obtain a referral) are my responsibility. Co-pays and co-insurances are due at the time of service. Failure to fulfill my financial obligation may result in my account being forwarded to an outside collection agency, which may result in additional fees and service charges. Delinquent accounts may be reported to the credit bureau. I also understand a fee will be charged for insufficient checks.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_