Chester County OB/GYN *Associates*

Offices in Downingtown, Kennett Square, Lionville and West Chester

PATIENT REGISTRATION FORM

Patient Information – PLEASE PRINT ALL INFORMATION Date: _____

Social Security Number: _____ Date of Birth_____

Last name: _____ First name_____ MI_____

Address: _____City:_____State:_____Zip:_____

Home phone: _____Alternate phone_____

Sex: M F ☐ Married ☐ Single ☐ Divorced ☐ Widow Race_____

Patient's occupation: _____ Student: ☐ full-time ☐ part-time

Employer: _____

Employer's address: _____City:_____State_____Zip:_____

Person Responsible for Payment – Only complete this section if patient is a minor or you have legal guardian

Name: _____Relationship:_____Date of Birth: _____

Social Security #_____Home Phone: _____Alternate phone_____

Address: _____City:_____State:_____Zip:_____

Occupation: _____Employer:_____

Employer's address: _____City:_____State:_____Zip:_____

Primary Insurance Information

Company: _____Subscriber's name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ other: _____

Subscriber's employer: _____Subscriber's date of birth: _____

Policy number: _____Group number or plan: _____

Secondary Insurance Information

Company: _____Subscriber's name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ other: _____

Subscriber's employer: _____Subscriber's date of birth: _____

Policy number: _____Group number or plan: _____

Referral Information – This information is important to us, please help us by completing this section.

How were you referred to this practice: _____?

Family physician: _____ Phone: _____

Address: _____City:_____State_____

Payment is expected at time of service unless other arrangements are made prior to visit.

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AUTHORIZATION TO RELEASE INFORMATION

Please contact me at: (check all that apply) ☐ Home ☐ Work ☐ Cell

May we leave a message for you at your home? ☐ Yes ☐ No

On your answering machine? ☐ Yes ☐ No

I authorize my doctor or nurse to release any information on my medical condition to the following people:

Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____

To authorize someone in addition to yourself to discuss billing issues with us, complete the following information:

Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____

At this time I do not want release of information to any other party.

_____ _____

Patient or responsible party signature Date

I understand that I have the right to revoke this authorization, in writing, at any time by giving notice of my revocation to the Privacy Office, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire when I am no longer a patient. I understand that information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. Chester County OB/GYN Associates may not condition treatment, payment, enrollment or eligibility for benefit on whether I sign this authorization.

Acknowledgment of Privacy Notice and Financial Policy

This policy will be given to you at the time of your first appointment.

I acknowledge receiving the Chester County Ob/Gyn Associates' Notice of Privacy Practices and Financial Policy

_____ _____

Patient or responsible party signature Date

FOR OFFICIAL USE ONLY

_____ _____

Verbal permission obtained by Date