Women's Health Inc. - Dr. Alan Binette **Patient Registration Form**

Patient Name: _____Age_____
(last) (first) (MI)

Date of Birth_____ Social Security #_____Preferred Name: _____

Physical Address_____

(Street) (City) (State) (Zip)

Mailing Address_____

(Street) (City) (State) (Zip)

Home Phone(_____)_____-_____ Cell Phone (_____) _____ -_____

Work Phone (____) _____-_____ Preferred Phone Number: Home Work Cell (Circle one)

Patient Employer: _____ Position_____

Spouse/ Parent Name: _____ Date of Birth: _____

Social Security # _____ Phone Number (_____) _____-_____

Spouse/Parent Employer: _____Work Phone (_____) _____-_____

Emergency Contact: _____Phone Number (____) _____-_____

Relationship

Primary Care Physician: _____ Referred by: _____

Primary Insurance: _____ **Secondary Insurance**: _____

ID/Policy Number_____ ID/Policy Number_____

Subscriber: _____ Subscriber: _____

Do you have a different Insurance for Pharmacy/Medications? Yes or No

If yes, please provide us with a copy of your insurance benefit card or complete the following:

(We are unable to facilitate any requests concerning medications or authorizations for medications without this information)

Insurance Company: _____ Subscriber: _____

ID/Policy Number _____ Group Number: _____

COPAYS ARE DUE AT TIME OF SERVICE

I authorize the release of any medical or other information necessary to process this claim, and that payment of the benefits be made directly to my provider of service. I understand I am responsible for all charges incurred should the insurance not pay for the services I receive. I understand it is my responsibility to supply current and correct insurance information. Women's Health Inc. will not be responsible for denial of claims when incorrect information is supplied.

Patient/Representative Signature: _____ Date:_____