Arizona Associates for Reproductive Health

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REGISTRATION FORM

DATE _____ { } MARRIED { } SINGLE { } SEPARATED { }DIVORCED { }PARTNERED

PATIENT LAST NAME _____ FIRST NAME _____ MI _____ SEX (please circle) M / F

AGE _____ DATE OF BIRTH _____ EMAIL _____

ADDRESS _____CITY _____STATE_____ ZIP_____

PHONE_____ CELL _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____ PHONE_____

ADDRESS _____ OCCUPATION _____

PRIMARY INSURANCE_____ PHONE_____

INSURED_____ ID#_____ GROUP_____

PRIMARY CARE DOCTOR _____ PHONE_____

REFERRING GYN PHYSICIAN _____ PHONE_____

SPOUSE

LAST NAME _____ FIRST NAME_____ MI_____

AGE_____DATE OF BIRTH_____ EMAIL_____

EMPLOYER_____ PHONE_____

OCCUPATION_____SOCIAL SECURITY NUMBER_____

REFERRING PHYSICIAN_____ PHONE_____

PRIMARY INSURANCE_____ PHONE_____

INSURED_____ ID#_____ GROUP_____

IN CASE OF EMERGENCY

NAME_____ PHONE_____

_____

Authorizations and Release (please initial)

_____If I have no medical coverage and/or benefits, I am aware that payment is due at the time of service when services are rendered

_____I am aware that I am responsible to pay co-pays and deductibles at the time of service.

_____I hereby authorize to release any MEDICAL information which might be needed in connection with payment for medical services rendered. I request that all amounts payable under my medical insurance policies be made directly to Arizona Associates for Reproductive Health. When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any services deemed non-covered by my insurance company.

_____I am aware that if I fail to pay my account and if it is deemed necessary to turn any past due balance over to collections, I have been informed that there will be additional costs accessed in addition to my account balance

_____I am aware that if I request my medical records, I understand to allow 2 weeks for the process of the release of medical records.

By signing below, I acknowledge that I have read and understand the above statements.

PATIENT SIGNATURE _____ DATE _____