

# WOMEN'S MEDICAL GROUP OF UPLAND, INC.

600 N. Mountain Ave., Suite A104 Upland, CA. 91786

(909) 931-1033 FAX (909) 981-8976

## REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Is this your legal name?	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex:
<input type="checkbox"/> Yes <input type="checkbox"/> No					/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security #:		Home phone #:		
					( )		
City:		State:		ZIP Code:		P.O. box:	
Occupation:		Employer & Address:				Employer phone #:	
						( )	
Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Mailing Address (if different):			Home phone #:	
		/ /				( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone #:	
						( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Primary insurance carrier:							
Subscriber's name:		Subscriber's S.S. # (Req.):	Birth date:	Group #:	Policy #:	Co-payment:	
			/ /			\$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
Name of secondary insurance (if applicable):		Subscriber's name:			Group #:	Policy #:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone #:	Work phone #:
			( )	( )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance whether or not paid by my insurance. I also authorize Women's Medical Group of Upland or insurance company to release any information required to process my claims.</p>				
<i>Patient/Guardian signature</i>			<i>Date</i>	



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ACKNOWLEDGEMENT OF RECEIPT  
OF  
NOTICE OF PRIVACEY PRACTICES

I acknowledge that a copy of the current Notice of Privacy Practices is posted in the reception area. I agree to read this notice at my convenience.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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

If not signed by patient please indicate:

Relationship:

\_\_\_\_\_ Parent / Guardian

\_\_\_\_\_ Beneficiary or Personal Representative

Patient Name: \_\_\_\_\_



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Please be advised that any lab fees and/ or bills that you may receive from the laboratory where your lab results are sent **are not** the responsibility of this office. Please contact your insurance if you are not sure what is covered by your insurance carrier.

Please sign that you have received this notice.

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

Thank you,

Women's Medical Group