COMPLETE HEALTHCARE FOR WOMEN OF WELLINGTON
PATIENT REGISTRATION FORM

PATIENT SEEING: ___DR. BROWN-GRAHAM ___ DR. PATEL

PLEASE PRINT "*ENTIRE*" FORM MUST BE FILLED OUT COMPLETELY

NAME: _____ HOW DID YOU HEAR ABOUT US? _____

STREET ADDRESS: _____ APT# _____ HOME PHONE: (_____) _____

CITY: _____ STATE: _____ ZIP: _____ MOBILE PHONE: (_____) _____

SS #: _____ DOB: _____ SEX: _____ MARITAL STATUS: ___S ___M ___D ___W

EMAIL ADDRESS: _____ CONTACT PREFERENCE: ____ HOME ____ MOBILE

PHARMACY OF CHOICE: _____ PHONE: (_____) _____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE: (_____) _____

EMPLOYER: _____ TITLE: _____ PHONE: (_____)_____

PRIMARY LANGUAGE: _____ RACE: _____ ETHNICITY: ____HISPANIC ____NON HISPANIC

SOMEONE TO CONTACT IN CASE OF EMERGENCY

NAME: _____ CONTACT PHONE (_____) _____ RELATIONSHIP: _____

IF PATIENT A MINOR, PLEASE COMPLETE THE FOLLOWING

FATHER'S NAME: _____ MOTHER'S NAME: _____

HOME PHONE: (____) _____ MOBILE: (____) _____ HOME PHONE: (____) _____ MOBILE: (____) _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO: _____

I.D. # _____

GROUP NAME OR # _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO: _____

I.D. # _____

GROUP NAME OR # _____

POLICY HOLDER INFORMATION

NAME: _____ SEX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS #: _____ DOB: _____

RELATIONSHIP TO POLICY HOLDER: _____
(self-husband-wife-child-other)

POLICY HOLDER INFORMATION

NAME: _____ SEX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS #: _____ DOB: _____

RELATIONSHIP TO POLICY HOLDER: _____
(self-husband-wife-child-other)

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physician in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. If your account was placed with a collection agency, you are required to pay the balance in full prior to scheduling an appointment. Timely payment will ensure your credit remains unaffected. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claims.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for charges not covered by insurance. I permit a copy of the authorization to be used in place of the original. ***Dr. Colette Brown-Graham & Dr. Daxa Patel are not participating providers with Florida Medicaid or Florida Medicaid assigned plans.***

Signature_____ Date _____