**BRANDYWINE WOMEN'S HEALTH ASSOCIATES**

# REGISTRATION FORM

(Please Print)

| Today's Date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ |
|---|---|---|---|---|---|

| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

| Chose clinic because/referred to clinic by (Please check one box): | ☐ Dr. | ☐ Insurance plan | ☐ Hospital |
|---|---|---|---|

| ☐ Family | ☐ Friend | ☐ Close to home/work | ☐ Yellow Pages | ☐ Cell Phone |
|---|---|---|---|---|

| Other family members seen here: | Email Address |
|---|---|

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ☐ Yes ☐ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

Is this patient covered by insurance? ☐ Yes ☐ No

| Please indicate primary insurance | ☐ MEDICARE | ☐ BC/BS | ☐ AETNA | ☐ COVENTRY | ☐ KEYSTONE |
|---|---|---|---|---|---|

| ☐ AMERI-HEALTH | ☐ TRI-CARE | ☐ CHAMPUS | ☐ MEDICAID *(Please provide card)* | ☐ Other |
|---|---|---|---|---|

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

| Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other |
|---|---|---|---|---|

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

| Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other |
|---|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

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. I also authorize **BRANDYWINE WOMEN'S HEALTH ASSOCIATES** or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*