

Haven Ob/Gyn, LLC

Patient Registration Form

Name _____ Today's Date _____
Last First MI

Street Address _____ Apt# _____ City _____

State _____ Zip _____ Home Phone # _____

Cell Phone # _____ Other Contact # _____

Date of Birth _____ SS# _____ Email _____

Ins. Comp. _____ Insurance Policy # _____

Who's responsible for payment _____ Group # _____

Significant Other's Name _____ SS# _____

Sig. Other Employer _____ Best Phone # _____

Emergency Contact (friend or relative not living with you): _____

Address _____ Phone # _____

Pharmacy _____ Phone # _____

How did you hear about us? _____ Another patient _____

Internet: Google _____ Kudzu.com _____ CallaDoctor.net _____ Other _____

Yellow Pages _____ Physician Referral _____ Other _____

I hereby consent to medical treatment by Haven Ob/Gyn, LLC. I authorize Haven or any holder of medical or other information about me to release to my insurance company information required in the course of my treatment for processing this or a future medical claim. I hereby authorize direct payment to Haven of any benefits payable for these medical services. I understand that I am financially responsible for payment of all services rendered regardless of insurance coverage and that I may be accountable for late fees and penalty charges for balances more than sixty days outstanding. I also realize that if my account is more than 60 days overdue I will be discharged from this medical practice and be unable to receive medical care at Haven in the future. I realize Haven follows all applicable HIPPA laws regarding the privacy of my medical information.

Signature _____

Is it okay to leave test results on your voicemail or answering machine? Yes _____ No _____

Is it okay for someone other than yourself to make/change appointments? Who? _____

Is it okay for someone other than yourself to receive medical information? Who? _____

We are honored you have chosen us as your health care provider.