

Monadnock OB-GYN Associates, P.A.

Patient Registration

Patient's Name: Maiden Name: Date of birth: Home Phone: Marital Status: Social Sec. number: Mailing Address: Residential Address: E-Mail: Do you check your email daily? Yes No

Name of Patient Employer: Name of Spouse Employer: Address: Address: Telephone: Patient Occupation: Telephone: Name of Spouse: Spouse Date of Birth: Spouse SS#: Name of Person Responsible for bill (after insurance): Address: Relation: Phone Number: Referred by: PCP name (if different) M.D. Address of PCP: Phone: Emergency Contact: Relationship: Address: Phone

Primary Medical Insurance Information: Secondary Medical Insurance Information: Company Name and Address: Subscriber: Group #: Effective Date: ID #: Subscribers Date of Birth

I hereby authorize payment directly to Monadnock OB-GYN, of the insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referrals and/or authorizations from my primary care physician and/or referring physician when required. I also authorize release of any information relating to my medical claim.

My signature also allows Monadnock OB-GYN physicians and/or staff to speak with the person(s) I designate re:

- medical condition, billing, appointments, test results, or to return a call to the office.
Permission to leave messages on unattended devices (i.e. answering devices/voice mail)
Permission to release correspondence, medication samples, prescriptions to family/friends with proper identification.

Name: Relation: Phone:

Name: Relation: Phone:

Signature of patient or authorized representative

Date