WOMAN'S HEALTH CENTER fleur OBSTETRICS & GYNECOLOGY

PATIENT REGISTRATION FORM

Please take few minute to complete this form. There may be times when it is urgent to contact you, so please try to be as complete and accurate as possible, especially with phone numbers. All information provided is completely confidential. Thank you.

Personal and Insurance Information

First Name | Middle Name | Last Name

Street Number | Street Name | Apartment Number

City | State | ZIP Code | Referred By (Physician, Internet or Phone Book)

SSN ___ - ___ - ___ | DOB (MM/DD/YY)

Home Phone | Cell Phone | Work Phone

Marital Status : ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name | Relationship | Phone

Race (White/Black African American, Asian/Pacific Islander (Multiple Selection Allowed) | Ethnicity (Hispanic, None Hispanic or Declined)

Employer Name | Occupation

City | State | ZIP Code

Primary Insurance Carrier | ID #

Subscriber Name (if different from patient) | DOB (MM/DD/YY) | Relationship to Subscriber

Secondary Insurance Carrier (if applicable) | ID #

Pharmacy Name | City and Cross Street | Phone

Do we have permission to:

Leave a message at your place of employment? ☐ Yes ☐ No

Leave a message on your answer machine? ☐ Yes ☐ No

Signature | Date and Time

72780 Country Club Dr. Suite A103 Rancho Mirage, CA 92270 760.779.5511