Overlake
Obstetricians & Gynecologists, PC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, M.I.)

Former Names (Maiden, etc.) | Preferred Name (Nickname, etc.)

Birthdate / / | Age | SSN

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated | Driver's License # | Primary Language

Race ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Caucasian ☐Other ☐Declined

Ethnicity ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Declined

Address Apt. # | City | State | Zip

Home | Work | Cell | Primary Number ☐Home ☐Work ☐Cell

Email ☐Personal ☐Work | **Permission to access past medication history (PBM)** ☐**Yes** ☐**No**

Employed by | Occupation

Primary Care Physician | Referred by | **Preferred Pharmacy & Location**

Spouse's Name (Last, First, M.I.) | Birthdate / /

Employed by | Occupation

How did you hear about us?

Local Emergency Contact Name of Person *NOT* living with you | **Relationship** | **Phone**

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION

You may share the following health care information with:

Name: _____ Relationship: _____

Please check all that apply:
☐ All health care information in my medical record ☐ Insurance and billing information
☐ Health care information in my medical record relating to the following treatment: _____
☐ Other (appointment, test results, etc.)

This authorization will be in effect until otherwise notified by the patient.

- May leave detailed message on voicemail at: Home # _____ Work # _____ Cell # _____
- May leave information with: ☐ Spouse/Partner or ☐ Family Member Name: _____
- May send text to remind you of upcoming appointments ☐ Yes ☐ No to # _____

X Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Department or Privacy Officer.

X Signature: _____ Date: _____

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(PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST)

INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account.

X Signature: _____ Date:_____

Primary Insurance _____ ID # _____ Group # _____

Primary Subscriber Name _____ Subscriber's DOB_____

Secondary Insurance _____ ID # _____ Group # _____

Secondary Subscriber Name _____ Subscriber's DOB_____