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 (Circle one) Single Married Divorced Widowed Separated	Driver's License #	Primary Language		
Race (Circle one) American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander Caucasian Other Declined				
Ethnicity (Circle one) Hispanic/Latino Non-Hispanic/Latino Declined				
Address Apt. #		City	State	Zip
Home ( )	Work ( )	Cell ( )	Primary Number (Circle one) Home Work Cell	
Email Personal		**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		
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: _____

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

- May leave detailed message on voicemail at: Home # _____ Work # _____ Cell # _____

X Signature: _____ Date: _____

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: _____

I have reviewed and verified that all demographic and insurance information is correct. There are no changes at this time.

X Signature: _____ Date: _____

X Signature: _____ Date: _____

(PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST)