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	**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)