Women's Medicine Collaborative ~ Patient Registration Form

Today's Date ______________________

Patient's Last Name ______________________ Middle Initial ____ First Name ______________

Marital Status: (S) (M) (W) (D) Maiden Name ______________________

Date of Birth ________________ Social Security # ____________________ Sex ________

Race ______________ *(State Requirement)* Language Preferred ________________ *(State Requirement)*

Address ____

City ______________________________ State __________ ZIP ______________

Home Phone # ______________________ Work/Cell # ______________________

Patient's Employer ______________________________ Phone # ______________

Primary Care Physician ______________________ Attending Physician ______________ *(Doctor you are here to see today)*

__Primary Insurance Information__ Insurance Name ______________________________

Subscriber's Name ______________________ Employment Status: FT, PT, Unemployed

Subscriber's Date of Birth ______________ *(required)* Subscriber's SS # ______________________

Group # ______________ Policy ______________________ Effective Date ______________

Subscriber's Employer ____

__Secondary Insurance Information__ Insurance Name ______________________________

Subscriber's Name ______________________ Employment Status: FT, PT, Unemployed

Subscriber's Date of Birth ______________ *(required)* Subscriber's SS # ______________________

Group # ______________ Policy ______________________ Effective Date ______________

Subscriber's Employer ______________________________

__Emergency Contact Information__

Contact Name ______________________________ Relationship to Patient ______________

Home Phone # ______________________ Work/Cell # ______________________

ADVANCED DIRECTIVES

Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.) Yes ❑ No ❑

Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent.) Yes ❑ No ❑

I would like the __Living Will and Durable Power of Attorney for Healthcare Booklet__.
Yes ❑ No ❑