THE WOMEN'S PAVILION, P.S.C.

PATIENT REGISTRATION

PATIENT'S NAME Last, First, MI	MARITAL STATUS S / M / W / DIV / SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

MAILING ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.	CELL PHONE NO.

PATIENT'S EMAIL

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE NO.
		EXT. ______

SPOUSE'S NAME	DATE OF BIRTH	SOCIAL SECURITY NO.	SPOUSE PHONE NO.

SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE NO.
		EXT. ______

GUARANTOR/EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NO.

SAME AS PATIENT ❏	MAILING ADDRESS	DATE OF BIRTH

Race (check all that apply)
- ❏ Asian
- ❏ African American
- ❏ African Indian
- ❏ Caucasian
- ❏ Declined
- ❏ Other________________

Language
- ❏ English
- ❏ Declined
- ❏ Other________________

Main Contact Number
- ❏ Cell
- ❏ Home

Ethnicity
- ❏ Hispanic/Latino
- ❏ Not Hispanic
- ❏ Declined

I HEREBY AUTHORIZE THE WOMEN'S PAVILION, PSC, TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND/OR TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

I CONSENT TO THE USE OF MY WIRELESS TELEPHONE NUMBER AND/OR TO MY EMAIL ADDRESS AS LISTED ABOVE. I CONSENT TO RECEIVE CALLS OR TEXT MESSAGES, AND/OR EMAIL FROM OR ON BEHALF OF THE WOMEN'S PAVILION, PSC FOR COLLECTION PURPOSES.

If your payment is delinquent more than sixty (60) days, all credit privileges may be cancelled and collection efforts may ensue. In the event collection efforts become necessary, patient/guardian shall be responsible for all collection costs and fees, including reasonable attorney fees. Further, patient/guardian agrees for any disputes or claims that the venue or jurisdiction shall be in Owensboro, Daviess County, Kentucky.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge by initialing I have received a copy of this office's Notice of Privacy Practices. ____________
initials

Date __________________ Patient Signature ____

Date __________________ Responsible Party Signature ____________________________________