Carteret Ob-Gyn Associates
Patient Registration Form

Your Name ____ Social Security Number _______________

Maiden/Other Name ___________________ Marital Status ______ Age________ Date of Birth____/_____/____

Your mailing address ____
(Street) (City) (State) (Zip code)

Your physical address ____
(Street) (City) (State) (Zip code)

Home phone # (_______) ____________ Work phone (______) ____________ Cell phone (____) ___________

Your E-mail address ____

Your Employer ____

Your Occupation __________________________________ ( ) Full time ( ) Part-time ( ) Self Employed

Husband's name ___________________ **Husband's** Social Security # _______________ **Husband's** Age ______

Husband's address (if different from above) ____

Husband's Date of birth _____/____/______ **Husband's** employer __________________________________

Husband's Occupation ________________________________ ( ) Full time ( ) Part-time ( ) Self Employed

Husband's Work Phone _________________

Name of your family doctor _______________________ How were you referred to our practice? ________________

Emergency contact (not husband) ____________________ Relationship _____________ Phone # (___) __________

INSURANCE CARD(S) MUST BE PRESENTED TO THE RECEPTIONIST AT TIME OF VISIT.

By my signature below:

- I authorize the release of any medical or other information deemed necessary by Carteret Ob-Gyn Associates including the transfer of all or a portion of my medical records to support medically necessary referrals to other health care providers.
- I authorize payment of medical benefits to Carteret Ob-Gyn Associates.
- I have read and understand the Financial Policy that has been provided to me.
- I acknowledge that I have been given a copy of Carteret Ob-Gyn's Notice of Privacy Practices.
- I understand that I will be billed separately from an outside agency if I receive any of the following services:
  - Blood draws
  - Urine cultures
  - Pap smears
  - Vaginal cultures
  - Mammogram reading
  - Pathology fee for biopsies or surgical procedures
  - Any other services that you may receive that are sent to an outside facility to be performed

Signature ______________________________ **Date** _________________________