Fort Sanders Perinatal Center
PC62050041 (04/22/13)

Patient Number
(for office use only)

PATIENT REGISTRATION

Last Name (as appears on ins. card)		First Name & Middle Initial	
Name you preferred to be called (if different from above)			
Mailing Address			
City	State	Zip	
Phone Number Cell Number e-mail Address	( ) ( ) _____ ☐ I approve to receive periodic communication from the Fort Sanders Perinatal Center via email.	Marital Status	S M D W
		How did you hear about our practice?	☐ Friend ☐ Family ☐ Internet ☐ Newspaper Radio Other _____
Date of Birth	Age	Referring/primary care physician	Social Security #
Employer		Employer Address & Phone No.	

Primary Insurance Company			
Policy Holder's Name		Policy Holder's Social Security No.	Date of Birth
Relationship to patient			
Member ID #		Group #	

Secondary Insurance Company			
Policy Holder's Name		Policy Holder's Social Security No.	Date of Birth
Relationship to Patient			
Member ID #		Group #	

Emergency Contact		Relationship To Patient		Phone Number	
Emergency Contact Not Living with you		Relationship To Patient		Phone Number	

If patient is a minor please fill out the following:

Parent or Legal Guardian Name	Address	Phone Number

Please read and sign:

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described, realizing I am responsible to pay non-covered services. I understand that if my account is turned over to a collection agency, I will be responsible for any applicable fees. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Patient's Signature_____**Date**_____

FORT SANDERS PERINATAL CENTER
A Member of FORT SANDERS REGIONAL MEDICAL CENTER