Desert Bloom OB/GYN Patient Registration Form (front)

Social Security Number	**Male** **Female**	Today's date

Patient Name (please print): **First**	**Middle**	**Last**

Street Address	**City**	**State**

(Apt, space, etc)	**ZIP CODE**	**Referring Provider**

Date Of Birth	**Home Phone**	**Other Phone**

Marital Status: Single Married Divorced Separated Domestic Partner Other:

Email address:

Employer Name	**Address**	**Work Phone Number**

If patient is under age 18, clinical correspondence will be mailed to parent/guardian at patient's address unless otherwise directed.____

Emergency Contact Information

Contact is: **Parent** **Guardian** **Spouse** **Domestic Partner** **Other:**		**Male** **Female**
First	Middle	Last
Day Phone	Evening Phone or other	
Address		

ADVANCE DIRECTIVES:

Does patient have A Living Will**?** **YES** **NO** ____ If YES, where is document kept?

Healthcare Power of Attorney**?** **YES** **NO** ____ If YES, list name & contact phone #

I have received a copy of Desert Bloom Ob/Gyn's " Notice of Privacy Practices."(sign & date below)

Signature______________________________________Date____________________________

Desert Bloom OB/GYN Patient Registration Form (back)

Patient Name *(please print)*	**Date of Birth**

Insurance Information

Plan #1 name		Plan address	
Group #	Start Date	Plan Phone #	Member ID #
Is patient also the policyholder? **YES** **NO**		**Policyholder's Name (if different from patient):**	
If no, patient's relationship to policyholder: Child Spouse Domestic Partner Other__________________________________		**Policyholder's Date of Birth**:	

Plan #2 name	Plan address	
Group #	Start Date	Member ID #
Is patient also the policyholder? **YES** **NO**	**Policyholder's name (if different from patient):**	
If no, patient's relationship to policyholder: Child Spouse Domestic Partner Other_________________________	**Policyholder's Date of Birth**:	

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize direct payments to physician for services rendered to me. I further authorize physician or its authorized representative to release any information related to such services to my insurance carrier in order to determine benefits. I understand that regardless of any available insurance that I am ultimately responsible for any incurred charges.
A photocopy or fax of these assignments shall be valid as the original.

Please bill my insurance on my behalf. **YES** **NO** ____

(Signature of patient or legal guardian)

GUARANTOR/RESPONSIBLE PARTY

Is patient responsible for paying all financial obligations? **YES** **NO**

If *NO*, please complete the following information for the Responsible Party:

Name	Phone	Relationship to patient
Street Address	City	Zip
Apt, Suite, Space #	SSN *Optional	Date of Birth