Fulton Center for Women's Health

1963 McDowell Road, Jackson, MS 39204
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PATIENT REGISTRATION FORM

(please answer all questions to the best of your ability)

Patient's Name: ______________________ SSN: ______________ DOB ______________
Age __________ Marital Status ______________________________

Address: ______________________________ City __________ State ______ Zip ______
Employer: ___________________________ Address ______________________
Home Phone: ______________ Work Phone: ________________ Cell Phone: __________
Email: ____

Spouse or Parent's Name ____________________ DOB __________ SSN ______________
Spouse or Parent's Employer: __________________ Occupation ________ Work Phone ________

Person Responsible for Bill (If different from above, please complete)
Guarantor's Name: ______________________ DOB __________ SSN ______________
Address: ______________________________ City __________ State ______ ZIP ______
Home Phone: ______________ Work Phone ______________ Employer ______________

Drug of Food Allergies? ____________________ Number of Children/ Ages ______________
Who should we notify in case of an emergency? ______________ Phone ______________

Has any member of your family been treated by one of our providers? ______________
Who referred you to our clinic? ______________________________

Insurance Information: (**if insurance cards are available to copy, please present to receptionist & omit this part**)
Primary Insurance Company: ______________________________
Address ______________________________________
Card Holder's Name ________________ Relation __________ DOB ______ SSN ______
Policy Number: __________________________ Group Number ______________
Secondary Insurance Company: ______________________________
Address ______________________________________
Card Holder's Name ________________ Relation __________ DOB ______ SSN ______
Policy Number: __________________________ Group Number ______________

Authorization for treatment, release of information, assignment of insurance benefits

I authorize Fulton Center for Women's Health to furnish medical treatment by those means considered necessary and proper in the treatment of the patient identified below while a patient of this facility. This treatment may require diagnostic procedures including, but not limited to, laboratory tests, blood drawing for those test, x-rays, and/or ultrasounds. I request that payment of authorized Medicare, Medicaid, or other third party insurances be made to Fulton Center for Women's Health. If assignment is accepted, in which case I agree to pay any deductible, co-payment, or charges not covered by this authorization. I authorize Fulton Center for Women's health to release to the Centers for Medicare and Medicaid and its agents or the Division of Medicaid or their fiscal agents or any third party insurance any information needed to determine these benefits. I authorize Fulton Center for Women's Health to retire x-ray films or any other graphic data four years after they are generated if a proper report is in the health record. For services rendered to the patient named below, I, the undersigned, agree to pay all professional, outpatient, and/or hospital visit charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment. The terms of this Consent for Treatment shall be valid until either party gives written notice of its termination. A copy of this assignment is as valid as the original.

______________________ ______________________________ ______________
Patient Name Signature of Patient/Guardian Date