REGISTRATION DATA FORM

PERSONAL INFORMATION

Name:_____

Address:_____

City, St, Zip:_____

Birth Date:_____ Age:_____

Social Security:_____

Home Phone:_____

Cell Phone:_____

Preferred method of contact:
Home Phone_____ Cell Phone_____
May we leave a message on your home/cell no?
Yes_____ No_____

Email Address:_____

Occupation:_____

Employer:_____

Work Phone:_____

Circle One: Married Single Divorced Other

If Married: Spouse Name:_____

EMERGENCY CONTACT INFORMATION

Name:_____
Phone Number_____
Relationship:_____

Today's Date:_____

Referred By:_____

Primary Physician:_____

Previous OB/GYN_____

Drivers License_____

Race (Required by ACA)_____
Declined_____
Ethnicity (Required by ACA)_____
Declined_____

INSURANCE INFORMATION

Insurance Carrier:_____

Address:_____

_____

Subscriber:_____

Subscriber ID #_____

Group #_____

Primary Policy Holder Information:

Name:_____

Social Security #_____

Date of Birth:_____

Employer:_____

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In exchange for professional services rendered by Keith Van Dyke M.D. and Marcella Bujnovsky, M.D., I hereby assign all medical and/or surgical healthcare benefits to which I am entitled (including all insurance types) to Van Dyke Gynecology This statement will remain in effect until and unless revoked by me in writing. A photocopy of this assignment can be considered to be as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. Outstanding balances are due within 90 days or will be sent to an outside collection agency. I understand I will be responsible for all fees associated with collection services. I hereby authorize said assignee (Dr's Van Dyke/Bujnovksy/staff) to release all information necessary to secure payment.

Signature _____ Date_____