Madison Women's Health LLP

REGISTRATION FORM 2

Patient Information

Last Name	First Name	M.I.	Previous/Former Names (please include multiple if applicable)		
Address		City	State	Zip Code	Gender ☐ F ☐ Other
Phone Numbers (please check preferred number) Home Phone ☐ ( ) - Work Phone ☐ ( ) - Mobile Phone ☐ ( ) -					
Date of Birth (mm/dd/yyyy)	Social Security Number (* please read below)		Email :		
Marital Status ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated	Employer				
Race (**please read below) ☐ Black or African American ☐ White ☐ Asian ☐ Multiracial ☐ American Indian or Native Alaskan ☐ Native Hawaiian or other Pacific Islander ☐ Declined ☐ Unavailable	Employer Address (City, State, Zip)				
	Occupation		☐ Full-time ☐ Part-time		
Ethnicity (**please read below) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unavailable	Who is your Primary Care Physician (PCP)?		How did you hear about us? ☐ Online/web search ☐ Radio ☐ Doctor ☐ Insurance directory ☐ Friend/family ☐ Other _____		

Contact Information

Emergency Contact - Primary	Emergency Contact - Secondary
Name	Name
Address	Address
City State Zip Code	City State Zip Code
Phone Number(s) 1. _____ ☐ Home ☐ Work ☐ Mobile 2. ☐ Home ☐ Work ☐ Mobile	Phone Number(s) 1. _____ ☐ Home ☐ Work ☐ Mobile 2. ☐ Home ☐ Work ☐ Mobile
Relationship to patient	Relationship to patient

Insurance

Primary Insurance Coverage/Medicare		Secondary/Other Insurance	
Insurance Name		Insurance Name	
Policy Holder ☐ Self ☐ Spouse ☐ Parent ☐ Other		Policy Holder ☐ Self ☐ Spouse ☐ Parent ☐ Other	
List policyholder, if not self		List policyholder, if not self	
Policy Holder's employer, if not self	Policyholder's DOB	Policy holder's employer, if not self	Policy holder's DOB
Occupation of policyholder, if not self		Occupation of policyholder, if not self	

_____ _____

Signature of Patient Date

PLEASE READ AND COMPLETE THE BACK SIDE OF THIS FORM

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* We strongly encourage you to provide your social security number. It is stored securely and will expedite finding your medical record on our system and ensure accurate claim filing.

** We are required by the State of Wisconsin to collect data regarding race and ethnicity. The State uses these data to assess health care provided to minority groups and to develop health programs. These categories are determined by the State.

NOTE TO PATIENT:

Please initial all individual consents below. If you do not wish to consent to any portion, please note "DO NOT CONSENT" and the date.

CONSENT FOR TREATMENT/ EVALUATION

_____ I consent to diagnostic procedure(s), medical treatment(s) and/or evaluation(s). I understand the purpose of this visit(s).

_____ I understand that Madison Women's Health, LLP assumes no liability for the loss of money or damage to articles of value.

CONSENT FOR BILLING & RELEASE OF MEDICAL INFORMATION FOR BILLING

_____ I assign the benefits payable for services outside of MWH to the organization furnishing the services (which may include, but is not limited to laboratory, pathology or radiology services).

_____ If applicable, I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim.

_____ I authorize MWH to release to my Insurance provider)(s) any medical information relating to this date of service for insurance processing, quality assurance, or utilization review. The information to be released for insurance processing will be diagnosis and/or documentation of service provided for which charges are made.

_____ The information to be released may include psychiatric, developmental disability, alcohol or drug abuse information, HIV testing, and AIDS or AIDS related disease diagnosis unless specified:

_____

_____ I understand that this authorization for releasing information will be effective for one year from the date of my signature unless otherwise stated below or revoked through written notice to the MWH

(Alternative date if not one year.) _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to MWH of the medical expense benefits otherwise payable to me by the insurance provider. I understand that I am financially responsible to MWH for charges not covered by Insurance.

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

Signature of Person Legally Authorized to Consent for Patient Printed Name of Person Legally Authorized to Consent for Patient

_____ _____

Reason for Signature of Person Other Than Patient Relationship to Patient

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