❑ JOHN M. MORGAN
❑ JACK B. FREEMAN
❑ HEIDI K. STRAUGHN
❑ JAMIE M. ROUTMAN
❑ HEATHER DEISHER

BROOKWOOD WOMEN'S HEALTH, P.C.
PATIENT REGISTRATION

CHART #_____

PLEASE PRINT
PATIENT INFORMATION:

Name _____ SS# _____

Street Address _____

City _____ State _____ ZIP _____ Email Add _____

Home # (_____) _____ Cell # (_____) _____ Marital Status M S D W

Date of Birth _____ / _____ / _____ Age _____ Race _____ Primary Language Spoken _____

Religion _____ Referred by _____

Patient's Employer _____ Position _____

Employer Address _____ Phone # _____

PHARMACY NAME: _____ **ADDRESS:** _____

SPOUSE/GUARANTOR INFORMATION:

Name _____ Relationship _____

Employer _____ SS# _____

Employer Address _____ Work # _____

EMERGENCY CONTACT PERSON

Name _____

Relationship to Patient _____ Phone # _____

INSURANCE INFORMATION

Name of **Primary** Insurance _____

Policyholder's name _____ Date of Birth _____

Policyholder's employer _____

Name of **Secondary** Insurance (if applicable) _____

Policyholder's name _____ Date of Birth _____

Poiicyholder's employer _____

Authorization to release information: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to my insurance company.

I hereby assign to and authorize directly to the above physician, all benefits payable under the terms of any insurance policy listed above. I realize the insurance benefit may not pay the entire bill. I agree to pay the difference of the entire bill if necessary. I also agree to pay costs of collection, including attorney's fee and waive my exemption under the constitution and laws of the State of Alabama.

_____

SIGNATURE DATE