**Registration and Insurance Information**

**Patient Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

Last Name First Name M.I. Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Address City State ZIP

Marital Status \_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed \_\_\_Separated

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Cell Phone Email Address

**Spouse or Responsible Party**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

Last Name First Name Date of Birth Sex

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If different from Patient) City/State Phone Number

**Emergency Contact**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Phone Number

**Insurance Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of Insurance Subscriber Subscriber DOB

**For All Patients**

I agree that I shall be legally responsible for any medical or surgical charge incurred in excess of any health insurance benefits that might be applicable.

I assign payment of authorized benefits to West Oakland OB/GYN and William Beaumont Hospital on my behaf for services rendered through West Oakland OB/GYN Clinic and the Professional Services Divisions of William Beaumont Hospital/Beaumont Reference Lab. I understand that I am responsible for the charges not covered by my insurance policy.

Release of Information:

I authorize West Oakland OB/GYN to release any medical information required by my health insurance company to process a claim, according to HIPPA regulations.

Consent To Testing:

In connection with certain diagnostic tests, I understand that specimens of blood, urine, and other bodily fluids, tissues, or products may be obtained and that tests will be performed upon such fluids, tissues, or products and I consent to this. I understand that if it becomes necessary I will be tested for antibodies of Human Immunodeficiency Virus (HIV, the virus that causes AIDS). I will be counseled by my physician and will be given the choice of consenting in writing to such testing. I have been informed that my written consent to testing for HIV antibody or other communicable disease is not required by law in situations where a health care provider sustains an exposure to my bodily fluids.

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Signature of Patient or Legal Representative Witness Date

**For Medicare Patients Only**

I request payment of authorized Medicare benefits to either myself or West Oakland OB/GYN on my behalf for services rendered through West Oakland OB/GYN and the Professional Services Division of William Beaumont Hospital/Beaumont Reference Laboratory. I authorize the holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Patient or Legal Representative Date

**Consent for Use and Disclosure of Your Health Information**

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose your health information in our possession.

The use and disclosure by this office are necessary and will be used in connection with your treatment, our obtaining payment for treatment and services that this office provides to you, and so that this office can conduct its health operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please review the Notice of Privacy Practices Form that this office has prepared and is furnishing for you. Please also see our Notice of Privacy Practices Form for a detailed discussion of the meanings of “treatment”, “payment”, and “health care operations”.

You have the right to review our Notice of Privacy Practices Form prior to signing this consent. Please be advised that the Notice of Privacy Practices Form may be revised by this office from time to time. Such revisions of the Notice of Privacy Practices Form will be made available to you by contacting our office manager.

You have the right to revoke this consent at any time. If you wish to revoke this consent, you may do so in writing.

By signing below, you acknowledge that you have read and understand this consent and this office’s Notice of Privacy Practices Form. You further acknowledge that you have received a copy of this office’s Notice of Privacy Practices Form to take with you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Patient or Legal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Patient or Legal Representative Date