



# Center for Pelvic Health

A Member of Saint Thomas Health Services

## REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Race:	Primary Language:	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ( )	
P.O. box:	City:		State:		ZIP Code:	
Occupation:		Employer:		Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						
Email Address:			Is it permissible to send you newsletters or communicate by email?: <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>INSURANCE INFORMATION</b>						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Medicare	<input type="checkbox"/> Commercial HMO	<input type="checkbox"/> Commercial PPO <input type="checkbox"/> Other	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )