

# Harmony Healthcare for Women, LLC REGISTRATION FORM

(Please Print)

Today's Date:			Primary Doctor:		
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	Marital status:	
				Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Social Security #
Street address:			Home phone #: ( )	Mobile phone #: ( )	
City:		State:	ZIP Code:		
Occupation:		Employer:		Employer phone no.: ( )	
Chose Dr. Kanoff because/referred 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:					

E-mail: \_\_\_\_\_ May we send you lab results and appointment reminders via e-mail?  Yes  No

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill if patient is a minor:		Birth date:	Address (if different):		Home phone no.: ( )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		Soc. Sec. #:			
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					
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group #:	Policy #:
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 #:	Policy #:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )
			Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Harmony Healthcare for Women, LLC to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	