

## Harmony Healthcare for Women, LLC REGISTRATION FORM

(Please Print)

Today's Date:			PCP:		
<b>PATIENT INFORMATION</b>					
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?	If not, what is your legal name?	(Former name):		Birth date:	Age:
<input type="checkbox"/> Yes <input type="checkbox"/> No					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 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

<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					
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.:
			( )
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.			
_____ Patient/Guardian signature			_____ Date