Maitri Health Care for Women
Obstetrics, Gynecology and Midwifery

REGISTRATION FORM (Please complete all sections)

Today's Date:	**PCP:**

PATIENT INFORMATION

Last Name: **First:**	Middle:	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:

Mailing Address:

_____

City/Town: _____

State: ____

Zip:_____ __

Social Security #:	(Please circle or designate your preferred contact #) Home phone :	Cell phone:
Occupation: Race: Language:	Employer: Employer phone #:	Your Email: Would you like to use the Patient Portal to have access to your records?? **Y / N**

(Please complete page 2 on other side)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name: (If patient Is subscriber, put **"self"**)	Subscriber's S.S. no.:	Birth date:	Group #:	ID #:	Co-payment: $ _____

Patient's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	ID #:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #:	Work phone #:

ADVANCE DIRECTIVE

Do you have an 'Advance Directive'?

( ) Yes, it is filed with the Vermont Advance Directive Registry

( ) Yes, it is filed with my primary care provider (PCP)

( ) Yes, it is filed with :_____

( )No, but I would like more information on how to file an 'Advance Directive'.

( )No, I'm not interested at this time

ASSIGNMENT AND RELEASE

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 Maitri Health Care for Women or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature **Date**