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 #)<br>Home phone : | Cell phone: |
|---|---|---|
| Occupation:<br><br>Race:<br><br>Language: | Employer:<br><br>Employer phone #: | Your Email:<br><br>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:**<br>(If patient<br>Is subscriber, put **"self"**) | Subscriber's S.S. no.: | Birth date: | Group #: | ID #: | Co-payment:<br>$ ___________ |
|---|---|---|---|---|---|

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**