

Patient Registration



Last Name		First Name	MI
Street Address		Email Address	
City, State, Zip		Social Security Number	
Home Phone () SEP	Work Phone ()	Cell Phone ()	Marital Status S M W D
Date of Birth	Age	Primary Care Physician	
Occupation/Employer		How did you hear about us?	
Spouse/Partner's Name	Spouse/Partner's Occupation	Spouse/Partner's Cell Number ()	
Emergency Contact: Name	Phone ()	Relationship	
Emergency Contact: Address		City, State, Zip	

Billing and Insurance Information

Covered services can only be billed to the insurance provided at the time of your visit. Payment for uncovered services is due prior to performance of the service. Lab and pharmacy bills are the patient's responsibility.

Release of Information/Assignment of Benefits

I authorize Women's Health Specialists of St. Louis, LLC to release to my insurance carrier(s), any information required for payment for all services for one year from the date below, unless otherwise specifically revoked. I request and authorize that my insurer(s) make payment directly to Women's Health Specialists of St. Louis, LLC for services rendered. **I understand that I am financially responsible for any charges, including lab and pharmacy services, or balances not covered by my insurance.** In the event my account is turned out to collections, I understand that any additional fees associated with this are my sole responsibility.

A photocopy of this assignment shall be valid as the original.

Signature _____ Date _____

Parent/Guardian _____ Date _____
(please print)