



Trinity Womens Care
GYNECOLOGY AND OBSTETRICS

PATIENT REGISTRATION AND INSURANCE INFORMATION

Patient Name: _____ Social Security # _____

Mailing Address: _____ City _____

State _____ ZIP Code _____ Date of Birth: _____

May we contact you at work? Y / N May we leave a detailed message on your home answering machine regarding normal test results? Y / N

Home telephone number: _____ Work telephone number: _____

Occupation: _____ Employer: _____

Alternate contact (for example, spouse) _____

Telephone number _____ Relationship to you _____

INSURANCE INFORMATION

If you do not have insurance, check here _____

Insurance Company _____ Effective Date _____

Name of Insured _____

If insured party is not you, please provide the following information regarding the insured person:

Date of Birth _____ Social Security Number _____

Relationship to you _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical or medical benefits to TRINITY WOMENS CARE for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize TRINITY WOMENS CARE to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand I may revoke this consent at any time by notifying TRINITY WOMENS CARE in writing. TRINITY WOMENS CARE has the right to refuse treatment should I revoke or refuse this consent.

Patient Signature _____ Today's date _____

Parent or Guardian Signature _____

