BARRINGTON OBSTETRICS & GYNECOLOGY
REGISTRATION FORM

Date: _____

Last Name: _____ First Name: _____ MI: ____

Home Address: _____

City: _____ State: ____ ZIP: _____ Driver's License #: _____

Phone Numbers: (Home) _____ (Work) _____ (Cell) _____

Date of Birth: _____ Social Security #: _____ Marital Status: _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: ____ ZIP: _____ Phone: _____

Spouse/Emergency Contact: _____ Phone: _____

Referred By: _____ Family Physician: _____

Insurance Information

Primary Insurance Company: _____ Copy of Card Attached: Yes / No

Coverage Type (circle): HMO / PPO / POS / EPO / Commercial Effective Date: _____

Policy Holder's Name: _____ Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Relationship to Patient: _____

Group Number: _____ Account Number (if not SSN): _____

Secondary Insurance Company (billed only for Medicare patients): _____

Effective Date: _____ Copy of Card Attached: Yes / No

Policy Holder's Name: _____ Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Relationship to Patient: _____

Group Number: _____ Account Number (if not SSN): _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I hereby authorize BARRINGTON OB/GYN PHYSICIAN(S) to examine me/my child and render treatment he/she feels necessary. I hereby authorize BARRINGTON OB/GYN to release any information acquired in the course of my or my dependents' examination and treatment to the insurance company(ies) listed. I understand that in order to control the cost of billing BARRINGTON OB/GYN requires that office visits be paid at the time service is rendered unless prior arrangements are made and that a $10 fee will be charged for any additional insurance filing.

Signed: _____ Date: _____