Dr. Mark F. Morrison, M.D.
PATIENT REGISTRATION FORM

SOC SEC #_______________________

PATIENT NAME____
(LAST) (FIRST) (MI) (BIRTHDATE)

ADDRESS____

CITY,STATE,ZIP____

HOME PHONE___________________WORK PHONE_____________________CELL PHONE____________________

MARRIED **DIVORCED** **SINGLE** **WIDOWED**

EMPLOYER NAME___________________________________ OCCUPATION__________________________

EMPLOYER ADDRESS________________________________ CITY,STATE,ZIP________________________

SPOUSE/SIGNIFICANT OTHER/PARENT INFORMATION

NAME____

ADDRESS____

CITY,STATE,ZIP____

PHONE# ____________________ WK PH__________________ EMPLOYER_____________________________

PHARMACY NAME_________________________LOCATION___________________PHONE#______________

FAMILY DOCTOR ____________________________ADDRESS_____________________PHONE#_______-____

PRIMARY INSURANCE INFORMATION	***SECONDARY INSURANCE INFORMATION***
INSURANCE NAME____________________________	INSURANCE NAME____________________________
ID #______________________GROUP#_____________	ID# ______________________GROUP#_____________
POLICY HOLDER NAME_________________________	POLICY HOLDER NAME_________________________
POLICY HOLDER BIRTHDATE_____________________	POLICY HOLDER BIRTHDATE_____________________
POLICY HOLDER SS# ___________________________	POLICY HOLDER SS# ___________________________

ASSIGNMENT OF BENEFITS: I/patient hereby authorize my signature on all insurance and Medicare claim forms at the office of Women's Health Center for payment directly to Dr. Mark F. Morrison for services rendered to me/patient. I authorize this office to release all information with respect to myself or any of my dependents which is necessary or required for the processing of claims under said insurance policy. I/patient understand that I am personally responsible for charges incurred whether my insurance pays or not. I/patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services I/patient received. I agree that this statement applies to all current and future claims.

SIGNATURE____DATE______________________________

OVER

EMERGENCY CONTACTS

NAME: ________________________ RELATIONSHIP _____________ PHONE NUMBER___________

NAME: ________________________ RELATIONSHIP _____________ PHONE NUMBER___________

I UNDERSTAND IT MAY BE NECESSARY TO DISCUSS MY MEDICAL INFORMATION WITH PERSONS OTHER THAN MYSELF. I AUTHORIZE THAT THE FOLLOWING PERSON(S) MAY BE CONTACTED ON MY BEHALF.

NAME: _________________________ RELATIONSHIP _____________ PHONE NUMBER__________

NAME: _________________________ RELATIONSHIP _____________ PHONE NUMBER__________

____

*SIGNATURE OF PATIENT/GUARDIAN DATE

PRIVACY ACT

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY RIGHTS AND PRACTICES AND HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THAT NOTICE.

____

*SIGNATURE OF PATIENT/GURADIAN DATE

CONSENT FOR PHONE CALLS:

By signing this agreement and providing Women's Health Center with my telephone number(s), I consent to Women's Health Center or its agents, contacting me at these telephone numbers, or at any other contact telephone number that is later acquired for me, and leaving live and/or pre recorded messages. I agree that calls may be delivered by an auto-dialer.

____

*SIGNATURE OF PATIENT/GUARADIAN DATE

CONSENT FOR MINORS:

I ____________________________GIVE MY PERMISSON FOR ____________________________TO RECEIVE

SIGNATURE PATIENT/GUARDIAN PATIENCE

MEDICAL TREATMENT FROM DR. MARK F. MORRISON OR ANY STAFF MEMBER. ____________________

DATE