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

SOC SEC #_____ EMAIL_____

PATIENT NAME_____
(LAST) (FIRST) (MI) (BIRTHDATE)

ADDRESS_____

CITY,STATE,ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

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

EMPLOYER NAME_____ OCCUPATION_____

**SPOUSE/SIGNIFICANT OTHER/PARENT INFORMATION**

NAME_____

ADDRESS_____ CITY,STATE,ZIP_____

PHONE# _____ EMPLOYER_____

PHARMACY NAME_____ LOCATION_____ PHONE#_____

FAMILY DOCTOR_____ ADDRESS_____ PHONE#_____-_____

***PRIMARY INSURANCE INFORMATION***

INSURANCE NAME_____

ID #_____ GROUP#_____

POLICY HOLDER NAME_____

POLICY HOLDER BIRTHDATE_____

POLICY HOLDER SS# _____

***SECONDARY INSURANCE INFORMATION***

INSURANCE NAME_____

ID# _____ GROUP#_____

POLICY HOLDER NAME_____

POLICY HOLDER BIRTHDATE_____

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 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 DATE

**CONSENT FOR CONTACT:**

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

_____

*SIGNATURE 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