Henrico Women's Health

Patient Registration

Patient Information

First Name ______________________________ Middle Initial_____ Last Name ____________________________________

Address ____ City __________________ State ________ Zip ____________

Primary Telephone (_____)_______________________Secondary Telephone (___)___________________________________

E-Mail Address ____

Date of Birth ______/______/________ Social Security Number ________-_______-_______ Marital Status ________________

Employment Status: (circle one) Retired Full time Part time Unemployed

Occupation _________________________________ Employer ____

Emergency Contact Person ______________________________Relationship __________ Telephone (_____)______________

May we release medical information to your emergency contact person? Yes No (circle one)

Responsible Party (if different from patient)

First Name ______________________________ Middle Initial_____ Last Name ____________________________________

Address ______________________________________ City ___________________ State _________ Zip ____________

Primary Telephone (_____) ______________________ Secondary Telephone (____) ______________________________

Date of Birth ______/_______/_______ Social Security Number ______-______-________

Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired – Full time – Part time - Unemployed

Occupation _______________________________________Employer ____

Medical Information

Referred By _______________________________ May we send a Thank You? _________________________________

Primary Care Physician's Name ____

Insurance Information

Primary Insurance Name ______________________________ Subscriber's Name _______________________________

Relationship to Policyholder (circle One) Self Spouse Child Other Subscriber's Date of Birth ____/____/____ Social _____-_____-______

Policy ID # ____ Group # ______________________________________

Secondary Insurance Name _______________________________ Subscriber's Name _____________________________

Relationship to Policyholder (circle One) Self Spouse Child Other Subscriber's Date of Birth ____/____/____ Social ______-_____-______

Policy ID # ____ Group # ____________________________________

MEDICAL SERVICES CONTRACT

I hereby authorize Robert P. McBride, III, MD to render medical services to me to release information regarding my medical history, examination, diagnostic studies, diagnosis and treatment to my insurance company regarding my claim for benefits. I authorize payment be made directly to Henrico Women's Health, PC for the benefits otherwise payable to me under the terms of my insurance policy. I understand that I am financially responsible for all charges arising from my treatment and agree that if my account is referred to an attorney or collection agency for collection, I will be responsible for all attorney and agency fees.

DATE______________________SIGNED____(RESPONSIBLE PARTY)