



## REGISTRATION FORM

(Please Print)

<b>Today's date:</b>				<b>PCP:</b>			
<b>PATIENT INFORMATION</b>							
<b>Patient's Last name:</b>		<b>First:</b>		<b>Middle:</b>		<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	<b>Marital status (circle one)</b> Single / Mar / Div / Sep / Wid
Is this your legal name?	If not, what is your legal name?			(Former name):	<b>Birth date:</b>	Age:	Student:
<input type="checkbox"/> Yes <input type="checkbox"/> No					/ /		<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Street address:</b>			<b>Social Security no.:</b>			<b>Home phone no:</b>	
						( )	
<b>CITY:</b>		<b>STATE:</b>		<b>ZIP CODE:</b>		<b>CELL #: or ALTERNATE:</b>	
						( )	
<b>Occupation:</b>		<b>Employer:</b>				<b>Work phone no.:</b>	
						( )	
<b>Whom may we thank for referring you to our practice:</b>				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:							

<b>INSURANCE INFORMATION</b>							
(Please give your <b>insurance card and photo id</b> to the receptionist.)							
<b>Person responsible for bill:</b>		<b>Birth date:</b>		<b>Address (if different):</b>		<b>Home phone no.:</b>	
		/ /				( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>Occupation:</b>	<b>Employer:</b>	<b>Employer address:</b>				<b>Employer phone no.:</b>	
						( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>PRIMARY INSURANCE:</b>							
Circle one:	HMO	PPO	Other:			<input type="checkbox"/> <b>Medicaid ID #</b>	
<b>Subscriber's name:</b>		<b>Subscriber's S.S. no.:</b>		<b>Birth date:</b>	<b>Group no.:</b>	<b>Policy no.:</b>	<b>Co-payment:</b>
				/ /			\$
<b>Patient's relationship to subscriber:</b>		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>SECONDARY INSURANCE IF APPLIC:</b>		<b>Subscriber's name:</b>				<b>Group no.:</b>	<b>Policy no.:</b>
<b>Patient's relationship to subscriber:</b>		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

<b>IN CASE OF EMERGENCY</b>							
<b>Name of local friend or relative (not living at same address):</b>				<b>Relationship to patient:</b>		<b>Home phone no.:</b>	<b>Work phone no.:</b>
						( )	( )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Colorado Springs Obstetrics &amp; Gynecology and my insurance company to release any information required to process my claims. I have read, understand and agree to the terms of CSOBYN's payment policy</p>							
<hr/> <i>Patient/Guardian signature</i>						<hr/> <i>Date</i>	