Women's Health Alliance, PA
PKA
Mid-Carolina Obstetrics & Gynecology, PC
The Medical Plaza at Rex Hospital
4414 Lake Boone Trail, Suite 300 * Raleigh, North Carolina 27607

Chart # _______________

## Patient Registration

Date _______________

Name_____________________________________________________________
Last First Initial Nickname

Date of Birth _____________________Marital Status _____________________

Address _____________________________________________________________

City______________________________________ State ______Zip ________

Telephone (Home) ______________ (Work) _____________ (Cell) _____________

Occupation______________________ Employer's Name _________________

Employer's Address _______________________________________________

Spouse/Partner's Name _____________________________________________

Spouse/Partner's Employer's Name ___________________________________

Spouse/Partner's Employer's Address _________________________________

Emergency Contact ________________________________________________

Relationship ___________________ Emergency Contact #_________________

Referred By _______________________________________________________

Please print the telephone number (If any) where you want to receive calls about your medical results, appointments, labs, etc. ________________

Please indicate if it is acceptable to leave a message on your answering machine/voicemail ___________________________ (Message Telephone #)

□ Yes, Please Leave Message □ No, Please Do NOT Leave Message

I, ___________________________ , understand the Federal HIPAA Guidelines.

I give permission to ________________________________________________
(Name) (Relationship)
to view or receive the medical information on my chart.

Patient's Signature _________________________ Date ____________________

This form is to be updated periodically at the provider's or patient's discretion

Women's Health Alliance, PA
PKA
Mid-Carolina Obstetrics & Gynecology, PC
The Medical Plaza at Rex Hospital
4414 Lake Boone Trail, Suite 300 * Raleigh, North Carolina 27607

Chart # _______________

## Insurance Information

Date _______________

Patient_______________________________________________________________

Insurance Company_________________________________________________
(Name as given on insurance Card)
_____________________________________________________________________
(Address for Insurance Company)
_____________________________________________________________________

Policy Holder _____________________________________________________
(Patient name, Spouse or Parent Name EXACTLY as it is given on insurance card)

Policy Holder Date of Birth ___________________________________________

Policy # ___________________________________________________

Group # ___________________________________________________

Employer __________________________________________________

Insurance Company Phone # __________________________________

☐ If you have more than one insurance carrier, please indicate here
Provide additional insurance coverage information on the back of this form exactly as shown above.

Policy Holder Name ________________________________________________

Policy Holder Date of Birth ___________________________________________

Relationship to Policy Holder _________________________________________

Patient Signature ___________________________________________________

**Note that without signature we will NOT, in confidentiality release medical information to your insurance company and cannot, therefore, file insurance claims for you. This signature also represents authorization for your insurance company to make benefits payable to our office. I also understand that my account is my responsibility to pay.**

This form is to be updated periodically at the provider's or patient's discretion