Aurora Womancare PC

Patient Registration Form

Name: Last_____First_____MI_____

Date of Birth: _____ SSN: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Race: _____ Marital Status: _____ Driver's License Number: _____

Email Address: _____

Pharmacy w/ cross streets: _____

Previous Primary Care Physician: _____

Emergency Contact: _____ Phone: _____

Relation to Emergency Contact: _____

Insurance: _____ Member ID #: _____ Group #: _____

Policy Holder: _____ SSN: _____ Date of Birth: _____

Policy Holder Employer: _____Patient Relation to Policy Holder: _____

Who referred you to Aurora Womancare? _____

I understand that without CURRENT insurance information, including an up to date insurance card, AWC may not be able to bill my claim. I also understand that AWC is not responsible to know the details of my insurance policy. I understand that it is my responsibility to inform AWC of any changes to my insurance coverage in a timely manner. Therefore, I accept FULL financial responsibility for inadequate insurance information. I also accept FULL responsibility for services that are not an insurance benefit. I have the right to refuse lab tests or treatment until I can verify my benefits.

Responsible Party Signature _____ Date _____