



321.674.2114 | f.321.674.2118

REGISTRATION FORM

(Please Type or Print) – All fields MUST be completed. Please see the front desk staff if you have any questions or need assistance, it will be our pleasure to help you complete your registration form.

Office Use Only Patient ID: _____	Referring / Primary Care Physician: _____ <small>(If your Insurance requires an authorization from you primary care physician you are responsible for bringing this with you the day of your visit)</small>
Today's date: _____	

PATIENT INFORMATION

<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Last name: _____	First: _____	Middle: _____
Street address: _____		City: _____	State: _____	ZIP Code: _____
Home Phone No: () - _____		E-Mail Address: _____		
Cell Phone: () - _____		Birth date: / / _____	Age: _____	Sex: _____
Social Security #: - - _____		(Please Check One) <input type="checkbox"/> Single / <input type="checkbox"/> Married / <input type="checkbox"/> Divorced / <input type="checkbox"/> Separated / <input type="checkbox"/> Widowed		
Employer: _____				
Occupation: _____			Employer phone no.: () - _____	
Pharmacy Name: _____			Pharmacy phone no.: () - _____	
Pharmacy Address: _____				
How did you hear about our office? (Please Select One)		<input type="checkbox"/> News paper / Magazine	<input type="checkbox"/> Internet	<input type="checkbox"/> Insurance Plan
<input type="checkbox"/> Zipper Website <input type="checkbox"/> Dr. _____		<input type="checkbox"/> Web Search	Other (Please explain): _____	
I have a living Will <input type="checkbox"/> Yes <input type="checkbox"/> No		I have a Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, please provide supporting documentation. Power of Attorney's Name: _____		

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist, she will make copies and/or scan them. As a courtesy we will file to your insurance) ** If you have more then 2 Insurances please let us know. There are additional forms you will need to complete.

Person responsible for bill: _____		Birth date: / / _____	Phone No.: () - _____
Address (if different from above): _____			
Relationship to Patient: _____	SS#: - - _____	Occupation: _____	
Employer: _____		Employer address: _____	
Work Phone: () - _____		How Long with this Employer? _____	
First Insurance	Name of Insurance Co.: _____		
Address of Insurance Co.: _____		Phone No.: () - _____	
Subscribers Name: _____		Relationship to Patient: _____	
Insures DOB: / / _____		Insurers SS #: - - _____	
Policy No.: _____		Group No.: _____	Co-Pay/Deductible: \$ _____
Second Insurance (If Applicable)		Name of Insurance Co.: _____	
Address of Insurance Co.: _____		Phone No.: () - _____	
Subscribers Name: _____		Relationship to Patient: _____	
Insurers DOB: / / _____		Insurers SS#: - - _____	
Policy No.: _____		Group No.: _____	Co-Pay/ Deductible: \$ _____

The above information is true to the best of my knowledge. I have read and understand the Notice of Privacy Practice presented to me at the front desk. I authorize my insurance benefits be paid directly to Zipper Urogynecology. I understand that I am financially responsible for any balance my Insurance does not pay or denies for any reason. I also authorize Zipper Urogynecology or my insurance company to release any information required to process my claims. I understand that authorizations will be obtained but are not a guarantee of payment. I understand that Medical Transcriptionists may have access to my medical records.

Patient Signature: _____	Today's Date: / / _____
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