Ob/Gyn
Associates of Holland P.C.

PATIENT REGISTRATION

Today's Date:_____

PATIENT INFORMATION PLEASE PRINT

Name (First/M.I./Last):_____ Maiden Name:_____
Address:_____ City/St/Zip:_____
Marital status:_____ Date of birth:_____ Social Security #:_____
Phone #'s: home:_____ cell:_____ work:_____
Preferred phone number (circle one): *home cell work* Email:_____
Preferred language:_____ Preferred Pharmacy:_____
Employer:_____ Occupation:_____
Primary Care Physician:_____ Ob/Gyn Physician:_____

EMERGENCY CONTACT

Name_____ Phone #:_____ Relationship:_____

RACE

□ Black/African American □ White □ Asian □ American Indian or Pacific Islander
□ Unknown □ More than one race □ Decline to respond

ETHNICITY

□ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Decline to respond

INSURANCE INFORMATION Please provide your current insurance card each time that you are seen.

Primary Insurance:_____
Policy Holder's Name (if other than patient):_____
Policy Holder's date of birth (if other than patient):_____
Relationship to patient: *spouse parent other*_____

Secondary Insurance:_____
Policy Holder's Name (if other than patient):_____
Policy Holder's date of birth (if other than patient):_____
Relationship to patient: *spouse parent other*_____

RESPONSIBLE PARTY FOR PAYMENT

Required only for patients under the age of 18.
Name:_____ Date of birth:_____
Address:_____
Phone number:_____ Relationship to patient:_____

Patient's Signature:_____ Date:_____

Guardian's Signature (if applicable):_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Ob/Gyn Associates of Holland, PC, is concerned about maintaining your confidential information. We will not release your information without your written permission except as outlined in our HIPAA policy. Ob/Gyn Associates of Holland, PC reserves the right to modify its privacy practices from time to time as required. By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Ob/Gyn Associates of Holland, PC.

Signature of patient or patient's representative Date

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

By signing below, I authorize Ob/Gyn Associates of Holland, PC to obtain/download my medication history from pharmacies and/or pharmacy benefit managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe, and to facilitate electronic pharmacy prescriptions. I understand that this authorization will remain in effect until revoked by me in writing.

Signature of patient or patient's representative Date

AUTHORIZATION TO TREAT

I agree to all care and treatment (including procedures when necessary) provided to me by the healthcare providers at Ob/Gyn Associates of Holland, PC. I understand that my care will be explained to me and that I will be a part of the decision making process. I understand that I should ask questions about my care to be certain that I understand the plan of care.

Signature of patient or patient's representative Date