Ob/Gyn
Associates of Holland P.C.

PATIENT REGISTRATION

Today's Date:_____

Patient ID #:_____

OFFICE USE ONLY

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:_____

Employer:_____ Occupation:_____

Primary Care Physician:_____ Ob/Gyn Physician:_____

EMERGENCY CONTACT

Name_____ Phone #:_____ Relationship:_____

RACE □ African American □ White □ Asian □ American Indian or Pacific Islander
□ More than one race □ Unknown □ 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:_____

Continued on next page.

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

Reviewed 5.2024