Medford WOMEN'S CLINIC LLP
obstetrics and gynecology
3170 State Street
Medford, OR 97504
(541) 864-8900 Phone
(541) 245-3315 Fax
www.medfordwomensclinic.com

Date: _____

PATIENT REGISTRATION				
LEGAL NAME:	First	Middle Initial	Last	DATE OF BIRTH:
HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? □ YES □ NO If yes, what name? _____				
SOCIAL SECURITY #:		MARITAL STATUS: Single Married Divorced Widowed		SEX: F or M
HOME PHONE:		CELL PHONE:		EMAIL:
STREET ADDRESS:				
Mailing Address:(if different)				
RACE:	□ White □ Asian □ Black □ Pacific Islander □ American Indian □ Other: _____			
ETHNICITY:	□ Hispanic or Latino □ Non-Hispanic or Non-Latino			
PREFERRED PHARMACY:	(Name & City)			
EMPLOYER:		OCCUPATION:		WORK PHONE:
EMERGENCY CONTACT: Name		Phone:		Relationship:

RESPONSIBLE PARTY OR CUSTODIAL PARENT (if different from patient)			
NAME:	ADDRESS:		
RELATIONSHIP:	SOCIAL SECURITY #:		DATE OF BIRTH:
HOME PHONE:	WORK PHONE:		CELL PHONE:
EMPLOYER:		OCCUPATION:	

PROVIDER INFORMATION	
Primary Care Provider: (Name & City)	Referring Provider: (Name & City)

INSURANCE INFORMATION (Check all that apply)			
□ MEDICARE	□ MEDICAID	□ OTHER HEALTH INSURANCE	□ NO INSURANCE

Primary Insurance Information				
Health Plan Name:		Address:		
ID/Policy #:		Employer (Group Name):		Group #:
Subscriber's Information: (if different from patient)	Name:			Date of Birth:
Relationship to Patient:	□ Spouse □ Child □ Other			SEX: F or M

Secondary Insurance Information: □ Not Applicable				
Health Plan Name:		Address:		
ID/Policy #:		Employer (Group Name):		Group #:
Subscriber's Information: (if different from patient)	Name:			Date of Birth:
Relationship to Patient:	□ Spouse □ Child □ Other			SEX: F or M

CONSENT & ASSIGNMENT OF BENEFITS: I hereby authorize & consent to an Obstetric and/or Gynecological evaluation, plan of care, treatment, or services as are considered necessary and advisable by my provider based on the medical information I provide.

ASSIGNMENT OF BENEFITS: I agree to and authorize the release of any medical or other information necessary to process medical claims. I also request payment of government benefits either to myself or to Medford Women's Clinic (MWC) who accepts assignment for medical insurance payments. I further authorize MWC to submit claims for payment for services without obtaining my signature on each claim to be submitted for myself or dependents. I understand my signature is required annually.

_____ _____ _____

Patient or Legal Representative's Signature | Patient or Legal Representative's Name (Please print) | Date