Locust Grove Women
Women's Health

1545 E. Leigh Field Drive Suite 100
Meridian, Idaho 83646
Phone: (208) 855-2710
Fax: (208) 855-0883

Registration Form

(Please Print)

PATIENT INFORMATION

Patient Last Name | First | Middle

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Marital Status (Check One): ☐ Single ☐ Separated ☐ Partnered ☐ Divorced ☐ Married ☐ Widowed

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former Name) | Birth Date / / | Age | Sex ☐ M ☐ F

Address | City | State | Zip | Social Security | Home Phone ( )

E-mail Address | Cell Phone

Occupation | Employer | Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ☐ Provider ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to Home/Work ☐ Website ☐ Yellow Pages ☐ Other

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill | Birth Date / / | Home Tel: ( )

Is the person a patient here? ☐ Yes ☐ No

Occupation | Employer | Employer Address | Employer Phone No. ( )

Is this patient covered by insurance? ☐ Yes ☐ No
Please indicate primary insurance

Subscriber's Name | Subscriber's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Secondary Insurance (if applicable) | Subscriber's Name | Group # | Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address) | Relationship to Patient | Home Phone ( ) | Work Phone ( )

The above information is true to the best of my knowledge. I authorize the physicians of Locust Grove Women's Health [LGWH} to provide myself or my child with reasonable and proper medical care according to today's standards. I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I also authorize LGWH or the insurance company to release any information required to process my claims. I understand that LGWH has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to LGWH I agree to forward to the clinic all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

X________________________ ________________________
PATIENT/GUARDIAN SIGNATURE DATE

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Please initial by each statement

____I (have) or (have not) been given the opportunity to read and/or receive a copy of Locust Grove Women's Health Privacy Notice.

____I understand that my medical records may be used for physician peer review and/or audit to improve our quality of core.

____I give permission for my protected health information to be disclosed for purposes of communicating results, finds and care decisions to the family members and others listed below:

____

____

____

Contact phone number:______________________________

______________________________ ______________

Patient or Personal Representative Signature Date

Relationship to Patient:______________________________