BEND OBSTETRICS & GYNECOLOGY, LLC
PATIENT REGISTRATION FORM

PATIENT INFORMATION (NAME MUST MATCH INSURANCE CARD) DATE____/____/_______

NAME ____ BIRTH DATE _____/_____/______ AGE ____
(Last) (First) (Middle)

FORMER NAME _________________ MARITAL STATUS ☐ SGL ☐ MAR ☐DIV ☐ SEP ☐ WID SS # (REQ) ____________________

STREET ______________________________ CITY ____________________ STATE____________ ZIP _______________

MAILING ADDRESS ______________________________ CITY ____________________ STATE____________ ZIP _______________

OCCUPATION __________________________ EMPLOYER ________________________________ WORK #(_____) ________-_________

HOME PHONE (_____) ________-__________ MAY WE LEAVE A DETAILED MESSAGE? ☐ Yes ☐ No

CELLULAR PHONE (_____) ________-__________ MAY WE LEAVE A DETAILED MESSAGE? ☐ Yes ☐ No

EMERGENCY CONTACT (_____) _________-_________ NAME _____________________________ RELATIONSHIP _________________

REFERRED TO CLINIC BY______________________________ OTHER FAMILY MEMBERS SEEN HERE ___________________________

NAME OF PRIMARY CARE DOCTOR ________________________________ PRIMARY DOCTOR PHONE ___________________________

RESPONSIBLE FINANCIAL PARTY (IF APPLICABLE)

NAME ____ RELATIONSHIP TO PATIENT ______________________

MAILING ADDRESS____
(Street or PO Box) (City) (State) (Zip)

PRIMARY PHONE (_____) ________-__________ ☐ HOME ☐ CELL ☐ WORK DOB: ______ /_____ / ______

SECONDARY PHONE (_____) ________-__________ ☐ HOME ☐ CELL ☐ WORK Driver's License # ____________________

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD AT CHECK IN)

PRIMARY INSURANCE______________________________________ SUBSCRIBER'S NAME ______________________________________

SUBSCRIBER BIRTH DATE ____/____/______ SUBSCRIBER SS # ______-____-_______

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE___________________________________ SUBSCRIBER'S NAME ______________________________________

SUBSCRIBER BIRTH DATE ____/____/______ SUBSCRIBER SS # ______-____-_______

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

The above information is true to the best of my knowledge. I authorize payment of medical benefits to Bend Obstetrics & Gynecology LLC. I also authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account.

_______________________________________ _______________________________________
PATIENT/ GUARDIAN SIGNATURE DATE