



5319 Parkshire Way • North Charleston, S.C 29418 • (843) 767-2121 • Fax: (843) 767-2102

PATIENT REGISTRATION

Name _____ SS# _____
Street Address _____ Date of Birth _____ Martial Status: S M W Sep D
City _____ State _____ Zip _____
Telephone: Home _____ Office _____ Cell _____
Email _____ I would like to receive email messages.
Referred by _____
Spouse's Name _____
Spouse's Employer / Address _____
Emergency Contact _____ Telephone _____ Relationship _____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Telephone _____
Employer Street Address _____ City / State _____ Zip _____
Patient's Occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Telephone _____
Street Address _____ City / State _____ Zip _____
Relationship to Patient _____

INSURANCE

Insured's Date of Birth _____ Insured's SS# _____
Medicaid # (if applicable) _____ Medicare # (if applicable) _____
Primary Insurance Company Name _____
ID # _____ Group # _____ Telephone _____
Secondary Insurance Company Name _____
ID # _____ Group # _____ Telephone _____

INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize CHARLESTON WOMEN'S WELLNESS CENTER to apply for benefits on my behalf for covered services by him/her or by his/her order. I request that payment from my insurance company be made directly to CHARLESTON WOMEN'S WELLNESS CENTER (or to party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____