WOMEN'S HEALTH CARE CENTER OF HOUSTON **PATIENT REGISTRATION FORM**

Last Name (Please Print) **First Name** (Please Print) **Middle Name**

Date of Birth: __ __-__ __-__ __ __ __ **Social Security:** __ __ __-__ __- __ __ __ __
Month Day Year
TELEPHONE: Home__ __ __-__ __ __-__ __ __ __ **Work**__ __ __-__ __ __-__ __ __ __ _____
Email address:_____ **Ext.**

_____ _____ _____, _____, _____
Address (Street number and name) APT # City State Zip
Marital Status: (Circle one) S M D W Sep If married, **Husband's Name**_____
Home Town (Birthplace)_____ **Ethnic Origin**_____
Referred by: _____
Emergency Contact: _____**Phone:** _ _ _ - _ _ _ - _ _ _ _
Religious Preference: _____ **Occupation:** _____
Employer: _____

PRIMARY INSURED PERSON'S INFORMATION

_____ _____ _____
(Last Name) (First Name) (Middle Name)
Insured's Relationship To Patient: **SELF SPOUSE PARENT OTHER** _____
Name of Insured's Employer: _____
Insured's Date of Birth__ __-__ __-__ __ __ __ **Work Phone** _____ -_____-_____
Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

INSURANCE COMPANY INFORMATION

NAME OF INSURANCE COMPANY_____
(Circle One) HMO PPO POS EPO Other ___ **Group or Plan#**_____
ID/SS No. (or Member or Cert Number)_____
Member Service/Customer Service Phone Number _____-_____-_____
Mail Claims to: _____
_____
_____
If HMO/POS, give Primary Care Physician's name and name of his/her network.

_____
Primary Care Physician's Phone Number __ __ __ -__ __ __ -__ __ __ __
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If patient is a **minor,** or is **mentally impaired,** please complete the following:
Parent/Guardian_____**Relationship**_____
Phone Number____-_____-_____ **Address:** _____
City_____**State**_____ **Zip Code:** _____

ALL PATIENTS (OR PARENT/GUARDIAN), PLEASE READ AND SIGN AUTHORIZATION BELOW

WHCCH has my permission to use the above information as needed for medical treatment of the patient and to obtain payment for services rendered. Date Signed _____
Signature: _____ **Printed Name** _____

03/2005 **Appointment Date**_____