REGISTRATION FORM
PLEASE PRINT CLEARLY

PLANTATION GYNECOLOGIC ASSOCIATES LLC
FEMCARE ASSOCIATES LLC

Section I: **PATIENT INFORMATION** **Date**_____

Name: _____ Social Security #: _____ Date of Birth: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Address: _____ City: _____ State: _____ Zip: _____ Apt#: _____

Home Ph. (_____) _____ Work Ph. (_____) _____ Ext: _____ Cell Ph. (_____) _____

Patient Employer: _____ Occupation: _____

Spouse Name: _____ DOB: _____ Phone #: _____

Spouse Employer: _____ Occupation: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

If patient is a minor: Parent/Guardian name: _____ DOB: _____ Ph. #: _____

Patient Email Address: _____

Primary Language Spoken: _____ Do you have a living will? ☐ Yes ☐ No

Section II **POLICY HOLDER INFORMATION**

Are you the primary policy holder of your insurance? ☐ Yes ☐ No

If you checked no, please fill out the information below:

Primary policy holder name: _____ Relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Partner

DOB: _____ Social Sec. No.: _____

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTABLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY. **IN ORDER TO CONTROL BILLING COSTS, IT IS THE POLICY OF PLANTATION GYNECOLOGIC ASSOCIATES, LLC. THAT CHARGES FOR OFFICE VISITS BE PAID BY THE CONCLUSION OF EACH VISIT.** PLEASE READ AND SIGN BELOW: I ACCEPT FINANCIAL RESPONSIBILITY FOR CHARGES INCURRED ON MY BEHALF INCLUDING COSTS OF COLLECTIONS (IF APPLICABLE) IN THE EVENT THAT INSURANCE FILED FOR SURGERY OR OTHER SERVICES RENDERED TO ME. I HERBY AUTHORIZE PLANTATION GYNECOLOGIC ASSOCIATES, LLC. TO RELEASE INFORMATION TO MY INSURANCE COMPANY AND ASSIGN BENEFITS DIRECTLY TO PLANTATION GYNECOLOGIC ASSOCIATES, LLC. SHOULD I HAVE A REMAINING BALANCE.

Patient Signature: _____ **Today's Date:** _____