



Women's Group of Franklin

Patient Registration

Patient Full Legal Name (Please do not use nicknames):				Preferred Name:		Date of Birth:	
Address:						☐ Single ☐ Married ☐ Divorced ☐ Widowed	
City:		State:		Zip Code:		Social Security #:	
Home Phone:		Work Phone:		Ext.:		Email:	
Race:		Ethnicity:		Preferred Pharmacy Name:			
Driver's License #:		Primary Language:		Preferred Pharmacy Phone Number:			
Preferred Method of Communication:		Phone	Email	Text	Patient Portal	Mail	Other
Patient's Employer:				Person with Primary Insurance:			
Employer Address:				Name of Insurance and Policy Number:			
Employer City:		State:		Zip:		Subscriber Social Security #:	
						Subscriber Date of Birth:	
Spouse/Parent:				Person with Secondary Insurance:			
Spouse/Parent's Employer:				Name of Insurance:			
Work Phone:		Ext.:		Subscriber Social Security #:		Subscriber Date of Birth:	
Contact in Case of Emergency:				Relationship to Patient:			
Emergency Contact Phone Number:				Emergency Contact Address:			
It is the policy of the office to require payment at the time services are provided. This includes full payment for uninsured individuals and co-payments or co-insurance for those on commercial insurance plans. If your account can not be collected by our office your account may be turned over to an outside collection agency. In addition, you will be responsible for any court cost, attorney fees, or collection agency fees incurred. By signing below, I am stating that I understand this policy. I understand that checks returned from my bank unpaid for any reason may result in additional charges with future services to be paid by cash or credit card. Also, by signing below, I am authorizing Women's Group of Franklin to furnish all the necessary information to my insurance company by phone, fax, electronic mail, or conventional mail which they may request to process claims or to comply with any audits that may be requested by my insurance company.							
Patient Signature:						Date:	
Parent or Guardian Signature (if under 18):							