north florida Women's Care
OBSTETRICS & GYNECOLOGY
1401 Centerville Rd., Suite 202 Tallahassee, FL 32308-4638
(850) 877-7241 Toll Free 1-855-Go-NFLWC (855-466-3592) Fax (850) 877-1338

Patient Registration

Patient's Name: Last_____First_____Middle Initial_____

Date of Birth:_____Age:_____SSN:_____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Other _____

Local Address:_____Apt #_____

City:_____State:_____Zip:_____County:_____

Alternate Address (If Different From Above):_____Apt #_____

City:_____State:_____Zip:_____County:_____

Home Phone #: ( ) _____ Cell Phone #: ( ) _____ Work Phone #: ( ) _____

Personal Email:_____

Employer:_____Occupation:_____

Primary Care Physician's (PCP) Name: _____ PCP Phone #: ( ) _____

Emergency Contact

Last_____First_____

Contact Phone #: ( ) _____ (Home / Cell / Work) Relationship_____

Primary Insurance Company:_____ Member Services#: ( ) _____

Member ID Number:_____Group #:_____Policy Holder: ❑ Self ❑ Spouse/Partner ❑ Parent

Member Name (as shown on insurance card): Last_____First_____Middle Initial_____

Date of Birth:_____SSN:_____Phone #: ( ) _____

Mailing Address:_____Apt #_____

City:_____State:_____Zip:_____

Secondary Insurance Company:_____ Member Services#: ( ) _____

Member ID Number:_____Group #:_____Policy Holder: ❑ Self ❑ Spouse/Partner ❑ Parent

Authorization and Assignment

I hereby assign all payments for services rendered to me or my dependents to North Florida Women's Care. This assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to insurance carriers concerning my illness and treatment.

Signed (Patient or Authorized Person):_____Date:_____