



Women's Healthcare Partners
Gynecology and Gynecologic Surgery

Patient Registration

63 W. Sunbridge, Fayetteville, AR 72703
479-582-FEMM (3366) Fax: 479-582-5843
www.renaissancewomenshealth.com

Internal Use Only



PATIENT NAME _____ DOB _____ SEX _____
 ADDRESS _____ APT _____
 CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ CELL _____ Email _____
 PLACE OF EMPLOYMENT _____ Work Phone _____
 SS# _____ Pharmacy Preferred _____ Street _____
 Please check one: Married Single Partner Divorced Widowed Separated
 Primary Care Physician _____

RESPONSIBLE PARTY _____ DOB _____
 RELATIONSHIP TO PATIENT _____ SS# _____
 PRIMARY INSURANCE COMPANY _____
 ID# _____ GP# _____ PHONE# _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____
 POLICYHOLDER'S NAME _____ DOB _____
 SS# _____
 SECONDARY INSURANCE _____
 ID# _____ GP# _____ PHONE# _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____
 POLICYHOLDER'S NAME _____ DOB _____
 SS# _____

EMERGENCY CONTACT _____ (relative or friend not in home)
 ADDRESS _____ PHONE # _____
 RELATIONSHIP TO PATIENT _____

ACKNOWLEDGEMENT OF PAYMENT

All professional services rendered are charged to the patient. The necessary forms will be provided to insure your prompt reimbursement by your insurance carrier. The responsible party is accountable for all fees, deductibles, and co-pays required by your insurance carrier. Payment is due in full the day services are rendered, unless we have a participating agreement with your insurance carrier.

Signed _____ Date _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION & INSURANCE ASSIGNMENT

I hereby authorize Renaissance Women's HealthCare Partners to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by insurance.

Signed _____ Date _____