Patient Registration Information

Name _____ **DOB**_____ **Marital Status** _____

Patient Address _____

City _____ **State** _____ **Zip**_____ **Social Security #**_____

please check the appropriate box if Central Phoenix OBGYN has permission to leave results or health information on your phone

***Home Phone** _____☐ ***Cellphone**_____☐ ***Work Phone** _____☐

Race _____ **Ethnicity** _____ **Email Address** _____

Employer: _____ **Phone:** _____

Emergency Contact:_____ **Phone:**_____

How did you hear about this office: _____

Who is your family doctor? _____ **Phone:** _____

Insurance Carrier: _____ **Policy Holder:** _____

Date of birth: _____ **Relationship to policy holder:** _____

Secondary Insurance: _____ **Policy Holder:** _____

Pharmacy Name: _____ **Phone:** _____

Pharmacy Address (cross streets): _____

I understand that payment is required at the time the service is rendered. Cash, personal check (with ID), Discover Card, MasterCard and Visa are accepted. Thank you for your assistance.

Patients Signature _____ **Date** _____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

This document acknowledges that I have seen the HIPAA Notice of Privacy Practices posted in this office and have had an opportunity to read it and obtain a copy of it.

Signature _____

Printed Name _____

Today's Date _____