



PATIENT REGISTRATION

Last Name _____ First Name _____ M.I. _____
 Home Phone# _____ Work Phone# _____
 Address _____ Cell # _____
 Alt. Address _____ Social Security # _____
 City _____ State _____ Driver's License# _____
 Zip Code _____ Marital Status _____
 Date of Birth _____ Religious Preference _____

Employer/School _____
 Address _____
 City _____ State _____ Zip _____

Who may we thank for referring you? _____

Nearest Relative _____ Address _____
 City _____ State _____ Zip _____ Phone _____

Insured's Name _____ SS# _____ Birth Date _____
 Employer _____ Address _____
 Business Phone # _____ Ext. _____

Primary Insurance _____ Policy # _____ Group # _____
 Insurance Company Phone# _____

Secondary Insurance _____ Policy # _____ Group # _____
 Insurance Company Phone # _____

Authorization To Release Information & Assignment

I hereby authorize Tyler Obstetrics & Gynecology L.L.P. and/or its staff to release all medical information to my current insurance carrier or its representative for purposes of claims administration, evaluations and/or determinations for medical care recommended and/or prescribed by my Doctor or his/her designated associates who may recommend or prescribe in his/her absence. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign Tyler Obstetrics & Gynecology, L.L.P. all money to which I am entitled for medical and/or surgical expense relative to the service rendered by Tyler Obstetrics & Gynecology, L.L.P. but not to exceed my indebtedness to said doctor and/or surgeon. It is understood that any money received from the above named insurance company/companies, over my indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctor for charges not covered by this assignment.

I hereby acknowledge that I have been presented with a copy of Tyler Obstetrics & Gynecology, L.L.P.'s Notice of Privacy Practice.

Insured or _____ Patients
 Guardians Signature _____ Signature _____

Date _____

INSURANCE INFORMATION

To verify that we accept your insurance, please fill out the form below and submit. All fields are required.

Patient's Name

Email Address

Carrier

Address for Claims

Name of Insured

Group Number

Policy Number

Insured SS#

Relationship to Insured

Phone No. for Insurance Co.

We do not accept Medicaid