PATIENT REGISTRATION

Name _____ **Driver License #**_____
(Last) (First) (MI)

Date of Birth _____ **Age** _____ **Male / Female** **Marital Status: S M W D**

Address _____ **City** _____ **State** _____ **Zip** _____

Phone (_____**)**_____ **Cell (**_____**)** _____ **Social Security #**_____

E-mail Address _____ **Referring Physician** _____

Employer _____ **Phone (**_____**)**_____

Employer Address _____

If Student, School Name _____ **Full-Time / Part-Time**

Responsible Party

Name _____ **Relationship to Patient** _____

Address _____

Phone (_____**)**_____**Cell (**_____**)**_____ **Social Security #** _____

Employer _____ **Phone Number (**_____**)**_____

Employer Address _____

Emergency Contact _____ **Primary Phone (**_____**)**_____

Insurance Information

Insurance Company _____ **Phone Number (**_____**)**_____

Address _____

Group #_____ **Certificate or ID #** _____

Policyholder's Name _____ **Relationship to Patient: Self / Spouse / Dependent**

Policyholder's Employer _____ **Phone Number (**_____**)**_____

Employer Address _____

Policyholder's Social Security # _____ **Date of Birth** _____ **Male / Female**

I hereby assign, transfer, and set over to Tyler Obstetrics & Gynecology, LLP all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____
Patient's Name (Printed) **Date**

_____ _____
Patient's Signature (or guardian if a minor) **Relationship (if minor)**