Bright Eyes MIDWIFERY & Wild Rivers WOMEN'S HEALTH CLINIC, LLC
PO Box 1710
Gold Beach, OR 97444
T: 541.425.5311
F: 541.425.5577

REGISTRATION FORM/CONSENT FOR TREATMENT
PATIENT INFORMATION

Full Legal Name: _____ D.O.B. _____ Age: _____ Sex: M F

Former Name: _____ Social Security Number: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Employer: _____

RACE: African American / Black _____ American Indian / Alaskan Native _____ Asian _____
Caucasian / White _____ Hawaiian / Pacific Islander _____ Prefer to not to Answer _____

ETHNICITY: Hispanic / Latino _____ Not Hispanic / Latino _____ Prefer to not Answer _____

INSURANCE INFORMATION

GUARANTOR NAME (self or guardian if the patient is under the age of 18): _____

D.O.B. _____ PHONE: _____ EMPLOYER: _____

PRIMARY INSURANCE: _____

ID NO: _____ GROUP NO: _____

SUBSCRIBER: _____ D.O.B: _____ RELATIONSHIP:_____

SECONDARY INSURANCE: _____

ID NO: _____ GROUP NO: _____

SUBSCRIBER: _____ D.O.B: _____ RELATIONSHIP:_____

CONSENT FOR TREATMENT AND BILLING

_____The above information is true to the best of my knowledge. I consent to evaluation and medically necessary treatment for which I have requested. I understand that there are no guarantees about the results of my treatment and may withdrawal my consent for treatment at any time. I understand that my insurance may be charged for any services I have received prior to my voluntary termination.

_____I authorize my insurance benefits to be directly paid to the physician. I understand that I am financially responsible for any uncovered balance. I also authorize Bright Eyes Midwifery & Wild Rivers Women's Health, LLC or my insurance company to release any information required to process my claims.

_____ _____
Patient/Guarantor Signature Date