**Greenwood Healthcare Specialists for Women, PLLC**

**1216 E. Apache St.**

**Tulsa, OK 74106**

**Phone: 918-794-5800**

**Patient Registration**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient's Last Name | | | First Name (Full Length) | | | | | | | Middle Name | | | | | | | | Nickname | | | | | | Maiden/Previous Name | | | |
| Address | | | | | | City | | | | | State | | | | | Zip | | | | | Marital Status (Please Circle)  Married Single Separated Widowed | | | | | | |
| Age | Date of Birth | | | | Sex (Please Circle)  Male Female | | | | Social Security Number | | | | | | | | | | | | Home Phone | | | | | Cell Phone | |
|  | | | | | | | | Patient Email Address | | | | | | | | | | | | | How would you like to receive future appointment reminders?(Please Circle) | | | | | | |
| Employer | | | | | | | | Occupation | | | | | | | | | | | | | Voicemail Email Text message | | | | | | |
| Employer's Address | | | | | | | | City | | | | | | State | | | | | | Zip | | | | | Business Phone | | |
| Spouse's Last Name | | | | | | | | First Name | | | | | | | | | Spouse's Social Security No. | | | | | | | | Spouse's Cell Phone | | |
| Spouse's Employer | | | | Business Phone | | | | | | | | Emergency Contact Name and Relationship | | | | | | | | | | | | | Emergency Contact Phone No. | | |
| Who referred you to our office? | | | | | | | | | | | | Primary Care Physician (Name, Address and Phone number) | | | | | | | | | | | | | | | |
| Preferred Pharmacy (Please specify closest main streets and city) | | | | | | | | | | | | Race – Hispanic Caucasian Native American  African-American Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Person Responsible for Bill Other Than Patient** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Responsible Party's Last Name | | | | | | | | First Name | | | | | Middle | | | | | | | | Relation | | | | | Home Phone | |
| Address | | City | | | | | | State | | | | | | | Zip | | | | | | | Business Phone | | | | | Date of Birth |
| Employer | | | | | | | | Occupation | | | | | | | | | | | | | Length of Employment | | | | | Cell Phone | |
| Employer's Address | | | | | | | City | | | | | | State | | | | | | Zip | | | | Social Security No. | | | | |
| **Insurance** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance Company | | | | | | | | Policy Holder's Name (From Card) | | | | | | | | | | | | | Policy No. | | | | | Group No. | |
| Policy Holders Social Security Number | | | | | | | | Date of Birth | | | | | Employer Name | | | | | | | | | | | | | | |
| Secondary Insurance Company | | | | | | | | Policy Holder's Name (From Card) | | | | | | | | | | | | | Policy No. | | | | | Group No. | |
| Policy Holders Social Security Number | | | | | | | | Date of Birth | | | | | Employer Name | | | | | | | | | | | | | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Greenwood Healthcare Specialists for Women or insurance company to release any information required to process my claims.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's or Responsible Party’s Signature Relationship Date Signed