**![GreenwoodLogo1[1].jpg]()Greenwood Healthcare Specialists for Women, PLLC**

**1216 E. Apache St.**

 **Tulsa, OK 74106**

**Phone: 918-794-5800**

**Patient Registration**

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| **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.

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