

PATIENT REGISTRATION

Reproductive Care of Indiana

Methodist Medical Plaza North

201 Pennsylvania Parkway, Suite 205
Indianapolis, IN 46280
Office: (317) 817-1800 or Toll Free: (888) 365-3436
Fax: (317) 817-1810

Professional Office Building, AP&S Clinic

1530 North 7th Street Ste 200
Terre Haute, IN 47807
Office: (888) 365-3436
Fax: (317) 817-1810

Lafayette Women's Clinic

3920 E. St. Francis Way Ste. 219
Lafayette, IN 47904
Office: (888) 365-3436
Fax: (317) 817-1810

Aegis Women's Clinic

2920 McIntire Drive, Suite 250
Bloomington, IN 47403
Office: (888) 365-3436
Fax: (317) 817-1810

Day _____ Date _____ Time _____

Patient's Name				
_____	_____	_____	_____	
(Last)	(First)	(Middle Initial)		
Maiden Name _____		Mother's First Name _____		
Patient Address				
_____	_____	_____	_____	
(Street)	(City)	(State)	(Zip Code)	
Home Phone _____	Cell Phone _____	DOB _____	Age _____	Sex _____
SS# _____	Marital Status _____			

Primary Care Physician _____ Street Address _____

City _____ State _____ Zip Code _____ Phone _____

Referring M.D. _____ Street Address _____

City _____ State _____ Zip Code _____ Phone _____

How did you learn about our medical practice? _____

EMPLOYMENT INFORMATION

Employer _____ Business Phone _____

Street Address _____ City _____ State _____ Zip Code _____

Occupation _____ May we contact you at work? _____ Hours _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION

Name _____ D.O.B. _____ SS# _____ Cell Phone _____

Employer _____ Business Phone _____ Occupation: _____

Street Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Company _____ ID# _____ Group# _____ Phone _____

(Please check correct answer)

Insurance through: Patient _____ Spouse _____ Significant Other _____ Parent _____ Other _____

Please list social security number and date of birth of person who carries you on insurance if not already listed above:

SS# _____ D.O.B. _____

IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial _____

Assignment and Release: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial _____

Financial Agreement: I understand the fees for all services rendered are the full responsibility of the patient. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial _____

I understand the above and fully understand the terms thereof:

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE