Obstetrix Medical Group of Coastal Carolina, PLLC
Wilmington Maternal Fetal Medicine

REGISTRATION FORM

(Please Print)

Today's Date:	Primary Care Physician Name:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ LifePartner

Sex: ☐ M ☐ F	Birth Date: / /	Age:	Email Address:

Street address:	Social Sec #:	Primary Phone #:( )

City:	State:	ZIP Code:	Other Phone#:( )

Occupation:	Employer:	Emp Phone #:( )

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Other:

Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ German ☐ Other:

Ethnicity: ☐ Hispanic/Latino ☐ Non- Hispanic/Latino ☐ Unknown
Religion: ☐ Baptist ☐ Catholic ☐ Methodist ☐ Other Christian ☐ Atheist ☐ Jewish ☐ Other:

How well do you speak English: ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

INSURANCE INFORMATION

Primary Insurance Name:	Subscriber's Name:	Subscriber's DOB: / /	Plan: ☐ PPO ☐ HMO ☐ Other ___________________

Policy/Identification #:	Group #:	Ins Phone #: ( )

Address:	City:	State:	ZIP Code:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary Insurance (if applicable)

Secondary Insurance Name:	Subscriber's Name:	Subscriber's DOB: / /	Plan: ☐ PPO ☐ HMO ☐ Other ___________________

Policy/Identification #:	Group #:	Ins Phone #: ( )

Address:	City:	State:	ZIP Code:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name:	Address:	Phone #:( )

Birth Date:	Relationship:	☐ Spouse	☐ Parent	☐ Other _________________________

EMERGENCY CONTACT INFORMATION

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone #: ( )	Work Phone #: ( )

Consent for Treatment, Authorization for Assignment of Benefits and Information Release

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

_______________________________ _______________

Patient/Guardian signature *Date*