FOR OFFICE USE ONLY

Primary Language: ________________

Interpreter needed? Y N

East Bay Perinatal Medical Associates

Patient Registration Form

Please print clearly:

Patient Last Name: ______________________________ First Name: ______________________________

Date of Birth: ____/____/____ Social Security Number: ______________________________

Address (Street): _____________________________________ City: ______________________________

State: _________ Zip: ________ Home Phone: (___) ____________ Work Phone: (___) ______________

Cell Phone: (___) ____________ Email: ___________________________

May we leave messages with confidential information (lab results, appointment information, etc.) at the numbers listed above? Yes No

Name of emergency contact: ______________________________ Relationship: ______________________

Phone Number: (___) _______________

Do you have an Advanced Directive for Health Care? Yes No

Patient's Employer: _____________________________________ Job Title: ________________________

Primary Care Physician: ________________________________ Phone: (___) _________________________

Referring Obstetrician: ________________________________ Phone: (___) _________________________

Why were you referred to our practice? ____

____

Primary Insurance: ______________________________ Group: ______________________________

Policy Number: _________________ Group Number: _____________ Phone Number: (___) ____________

Policy Holder: __________________ Relationship to Patient: ____________ Date of Birth: ____/____/____

Social Security Number: __________________________

Secondary Insurance: ______________________________ Group: ______________________________

Policy Number: _________________ Group Number: _____________ Phone Number: (___) ____________

Policy Holder: __________________ Relationship to Patient: ____________ Date of Birth: ___/____/____

Social Security Number: __________________________

I understand that I am financially responsible for all charges, whether or not they are paid by my insurance. I hereby authorize East Bay Perinatal Medical Associates to release all information necessary to secure payment of services rendered. *We have a 24-hour cancellation policy and reserve the right to charge a fee for last minute cancellations or missed appointments.*

____ _____________________________

Patient Signature Date