WOMEN'S HEALTH GROUP, INC.

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Registration Form (Please Print)

First Name:_____ **MI:**_____ **Last Name:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Pharmacy:_____ **Date of Birth:**____/____/_____ **Social Security No:** ____-___-_____

Employment :_____ **Position** _____

Cell Number: (____)_____-_____
___ OK to leave a detailed message (text or vm)
___ Leave a message with only call back numbers

Home Number: (____)_____-_____
___ OK to leave a detailed message
___ Leave a message with only call back numbers

Work Number: (____)_____-_____
___ OK to leave a detailed message
___ Leave a message with only call back numbers
Direct line? Yes [ ] No [ ]

E-mail: _____
___ OK to send e-mail regarding health information
___ Do NOT e-mail personal health information

Race:_____ **Ethnicity:**_____ **Preferred Language:** _____

Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ]

Employer: None [ ] Retired [ ] Full time [ ] Part-Time [ ]

Name of Employer: _____ **City:**_____ **State:**_____ **Zip:**_____

Emergency Contact:_____ **Number:**_____ **Relationship:**_____

Primary Care Physician (First/Last Name): _____ ***Number:***_____

Referred to Practice by (Check one): WHG Website [ ] Google [ ] Facebook [ ] YELP [ ] Other web-site [ ]
Insurance Provider Search [ ] Friend/Family Member [ ] Doctor [ ] _____

Primary Insurance: _____

Policy Holder:_____**DOB:**___/___/___

ID Number:_____**Group:**_____

Relationship to holder: Self [ ] Spouse [ ] Child [ ]

Secondary Insurance: _____

Policy Holder:_____**DOB:**___/___/___

ID Number:_____**Group:**_____

Relationship to holder: Self [ ] Spouse [ ] Child [ ]

*Copays and balances are due at the time of service and are to be collected at the front desk upon arrival. We will bill only two contracted insurance companies; however you are ultimately responsible for all charges whether the insurance company paid for your claim or not. We accept checks, cash and most major credit cards.

I hereby authorize WOMEN'S HEALTH GROUP INC., to disclose my individually identifiable health information to the insurance carrier(s). WOMEN'S HEALTH GROUP INC., will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

PATIENT GUARDIAN and/or INSURED SIGNATURE:_____ **DATE:**_____

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is against the law.

The Women's Health Group complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Women's Health Group does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

The Women's Health Group

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as**
  - Qualified sign language interpreters
  - Written information in other formats (larger print, audio, accessible electronic formats, or other formats**)**
- **Provides free language services to people whose primary language is not English, such as**
  - Qualified interpreters
  - Information written in other languages

If you need any of the above named services, contact **Carolyn Raybuck**, practice administrator of The Women's Health Group.

If you believe that The Women's Health Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Carolyn Raybuck, Practice Administrator, 121 Northwest Avenue, Tallmadge, OH, 44278**, by phone: **330-633-1350**, by fax**: 330-633-6068 ATTN: Carolyn Raybuck**, or by email **whgroup@hotmail.com**.

Signature of Notified Individual: _____ Date:_____