

Far Hills OB-GYN, Inc.
REGISTRATION FORM

PATIENT INFORMATION							
Last Name		First Name		Middle Name		Maiden Name	
Address				City/ State		Zip	
DOB	Age	Relation to Responsible Party		S.S. #	Home Phone	Work Phone	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Employer Name & Address			Employment Status <input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Part time <input type="checkbox"/> Not Employed		Cell Phone	
Referring Physician		Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Patient Student Status: <input type="checkbox"/> Part time <input type="checkbox"/> Full Time <input type="checkbox"/> Not a student			
Name of other family members coming to this practice:							

<input type="checkbox"/> SAME AS PATIENT RESPONSIBLE PARTY INFORMATION (If different from patient) <i>Person who accompanies child to visit</i>							
Last name		First Name		Middle Initial		Maiden Name	
Address		S.S.#		Home Phone		Cell Phone	
City, State, Zip		Relationship to patient				Employer Name	
Spouse		Spouse Employer & Address				Spouse work phone	
						Birthdate	
						Work Phone	

EMERGENCY CONTACT (spouse or nearest relative)			
Emergency Contact Name		Home phone	
Address, City, State & Zip		Work Phone	
		Other Phone	
		Relation to Patient	

PRIMARY INSURANCE INFORMATION				
Insurance Company	Group# / Plan ID	Member Number	Copay Amount	Effective Date
Subscriber Employer Name & Address		Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Child to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name		Does your insurance require A referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

SECONDARY INSURANCE INFORMATION				
Insurance Company	Group# / Plan ID	Member Number	Copay Amount	Effective Date
Subscriber Employer Name & Address		Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Child to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name		Does your insurance require A referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to Far Hills OB/GYN, Inc. to render needed treatment and/or tests for the above named patient.
2. I authorize Far Hills OB/GYN, Inc. to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to Far Hills OB/GYN, Inc., realizing I am responsible to pay noncovered and unauthorized service.
4. I understand that **I am responsible** for charges incurred through Far Hills OB/GYN, Inc. not covered by my insurance. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. If you are unable to keep your appointment, 24 hour cancellation notice is required. If you miss your appointment without notifying our office, you will be charged \$25.00 after the third occurrence and each time thereafter. This charge is not billable to your insurance. If you are more than ten minutes late for an appointment, you will need to reschedule. It is unfair to our other patients to make them wait when they have arrived on time.

The above information is correct / Patient or Guardian Signature

Date