Premier Women's Health, LLC

5404 Hillandale Park Court
Lithonia, Ga 30058
(678) 418-6990 Office
(678) 418-6986 Fax

Registration

(Please Print)

Date _____

PATIENT REGISTRATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ St ____ Zip _____

D.O.B. _____ E-mail _____ SS# _____

Home Phone (___)_____ Cell Phone (____)_____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School # _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone # _____

What is your pharmacy name? _____ Phone # _____

PRIMARY INSURANCE

Person Responsible for Account _____

Relation to Patient _____ Birth Date _____ SS# _____

Address (if different from patient's) _____ City _____

State_____ Zip Code _____

Person Responsible employed by _____

Occupation _____ Business Phone (___)_____

Insurance Company _____

Contract # _____ Group # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____ Yes or No

Subscriber Name _____ Birth Date _____

Relation to Patient _____

Address (if different from patient's) _____

Subscriber Employed by: _____ Business Phone (____)_____

Insurance Company _____ SS # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Dr. Dominique Smith all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Guardian, or Personal Representative Date

_____ _____

Signature of Patient, Guardian, or Personal Representative Date