Raleigh Gynecology
& Wellness, PA

PATIENT REGISTRATION FORM
Please Print

Name: _____ Preferred: _____

Date of Birth: _____ Social Security # _____

Phone: (Home) _____ (Cell) _____ Email: _____

Preferred Communication: Cell / Text / Home

Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent: _____ Emergency Contact# _____

Primary Insurance: _____

Insured: _____ Policy Holder: _____

Relationship to Patient: _____ SELF _____ SPOUSE _____ PARENT

Subscriber ID: _____ Group#: _____

Effective Date: _____ Policy Holder Date of Birth: _____

Secondary Insurance: _____

Insured: _____ Policy Holder: _____

Relationship to Patient: _____ SELF _____ SPOUSE _____ PARENT

Subscriber ID: _____ Group#: _____

Effective Date: _____ Policy Holder Date of Birth: _____

Payment Agreement

I AGREE TO PAY RALEIGH GYNECOLOGY & WELLNESS, PA FOR ANY SERVICES NOT COVERED BY MY INSURANCE COMPANY. I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION TO THE ABOVE INSURANCE CO. AND AUTHORIZE PAYMENT DIRECTLY TO RALEIGH GYNECOLOGY & WELLNESS, PA.

SIGNATURE _____ DATE _____