COMPREHENSIVE OB GYN PA

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SARIYE SAVCI, MD
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PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT CLEARLY)				
Last Name: First: Middle:			Marital Status (circle one): Single / Mar / Div / Sep / Wid	
Former Name (if applicable):	Social Security Number: __ __ __ - __ __ - __ __ __ __	Birth Date (M/D/YY): / /	Age:	Sex (circle one): ☐F ☐M
Street Address:		Apartment/Floor:	Primary Phone Number: ( )	
City:	State:	ZIP Code:	Secondary Phone Number: ( )	
Occupation:	Employer:		Work Phone Number: ( )	

EMERGENCY CONTACT INFORMATION		
Emergency Contact Person (full name):	Relationship to Patient:	Emergency Phone Number: ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST AFTER COMPLETION OF FORM)	
Is this patient covered by insurance? ☐Yes ☐No	SUBSCRIBER'S INFO (IF NOT SELF)
Insurance Company:	Full Name:
ID Number on Card:	Birth Date: / /
Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other	SS Number: __ __ __ - __ __ - __ __ __ __

RESPONSIBLE FINANCIAL PARTY (IF DIFFERENT FROM PATIENT)			
Name:	Relationship to Patient:	Birth Date (M/D/YY): / /	Social Security Number: __ __ __ - __ __ - __ __ __ __
Mailing Address (if different from patient):		Apartment/Floor:	Primary Phone Number: ( )
City:	State:	ZIP Code:	Secondary Phone Number: ( )

PLEASE READ THE FOLLOWING AND SIGN BELOW

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I acknowledge that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that if a bill is not paid by my insurance, I agree to make arrangements for prompt payment of my bill.

Patient/Guardian Signature: Date:

NOTICE OF PRIVACY RECEIPT

I acknowledge receipt of Comprehensive Ob Gyn PA's "Notice of Privacy Practices".

Patient/Guardian Signature: Date: