

Western Carolina Women's Specialty Center, P.A.

Patient Registration

First Name & Middle Initial _____ Last Name _____

Date of Birth _____ SS # _____ Marital Status M/S _____

Address _____ City _____

State _____ ZIP _____ Home Phone _____ Work/Cell Phone _____

Referred By _____ Family Doctor _____

Employer _____ Employer Phone _____

Emergency Contact _____ Relationship _____

Phone _____

If Under 18

Name of Parent or Guardian _____ Relationship _____

Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____

ZIP _____ Home Phone _____ Work Phone _____

Parent or Guardian Consent to Treat Minor _____ Date _____

Please supply your insurance card to us upon each office visit.

Insurance Carrier (**Primary**) _____

Insured's Name _____ Date of Birth _____

Insured's Employer _____ Insured's SS# _____

Insurance Carrier (**Secondary**) _____

Insured's Name _____ Date of Birth _____

Insured's Employer _____ Insured's SS # _____

*Insurance co-pays and co-insurance amounts are **due at the time of service** as required by your insurance carrier.*

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE OF INFORMATION: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Patient or Guardian Signature _____ Date _____

I hereby authorize the Physician to release any information acquired in the course of my treatment which is necessary to process insurance claims.

Patient or Guardian Signature _____ Date _____

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