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progressivewomenshealthonline.com

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PROGRESSIVE WOMENS HEALTH, PLLC
ASIA MOHSIN, MD

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Martial Status: _____ Sex: M / F
Address: _____
City: _____ State: _____ Zip Code: _____ Social Security Number: _____
Home Phone: _____ Work Phone: _____ Email: _____
Who is responsible for this patient? _____ Relationship to patient: _____
Referral Source: _____
In case of emergency please notify:
Name: _____ Telephone: _____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

EMPLOYER INFORMATION

Responsible Party: Employer Name: _____ Employer Phone: _____
Employer Address: _____
Spouse/Guardian: Employer Name: _____ Employer Phone: _____
Employer Address: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Name of policyholder: _____
Policy holder's SSN: _____ Address: _____
Policy Number: _____ Group Number: _____

Secondary Insurance Company Name: _____ Name of policyholder: _____
Policy holder's SSN: _____ Address: _____
Policy Number: _____ Group Number: _____

**********PLEASE SIGN IN **BOTH** BOXES **********

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of all medical/insurance benefits to Progressive Womens Health (PWH), PLLC for all covered clinical services or supplies, provided to me during my course of treatment at PWH. I also authorize payment of government benefits (e.g. Medicare), If applicable, to PWH. I understand and agree that this assignment of benefits will have continuing effect for as long as I am being treated at PWH and as long as PWH needs it for claims processing and payment, related to the treatment I receive at PWH. SIGNED: DATE:	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:** I understand that all payments are due at the time of service and I am financially responsible for all charges whether paid or not by the insurance company. A photocopy of this assignment is to be considered as valid as original. I authorize the release of any medical or other necessary information to process my insurance claims. SIGNED: DATE: