Lifespan Physician Group, Inc.

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone ( )

City	State	Zip Code	Alternate Phone ( )

Marital Status (circle one) Single / Married / Divorced / Separated / Widowed / Life Partner / Civil Union	**Preferred Language** Spoken: _____ Written: _____ Interpreter Required? ☐YES ☐NO

Sex: ☐Female ☐Male Religion:

Race (circle one): American Indian / Alaskan Native / American Indian & Native Hawaiian / Asian / Asian & America Indian / Asian & Native Hawaiian / Black & Asian/ Black & American Indian / Black & Native Hawaiian / Black-African American / White / White & American Indian / White & Asian / White & Black / White & Native Hawaiian / Other **Hispanic/Latino (circle one):** Hispanic / Non-Hispanic

Are you Employed? ☐YES ☐ NO	Employer	Occupation	Employer Phone ( )

How did you hear about us?

Provider you are here to see today?

Primary Care Provider (PCP)/Practice Name	PCP Phone ( )

Pharmacy	Address	Pharmacy Phone ( )

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )

Is this patient covered by insurance? ☐ Yes ☐ No	Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Employment Status ☐ Full Time ☐ Part Time ☐ Unemployed	Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Subscriber's Employment Status ☐Full Time ☐ Part Time ☐Unemployed	Subscriber's Employer

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Alternate Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lifespan Physician Group, Inc.-Ob Gyn Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ☐Yes ☐No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ☐Yes ☐No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ☐Yes ☐No