



Patient Registration Form
Obstetrics & Gynecology

Today's Date \_\_\_\_\_

How did you hear about us? [ ] Referred by a friend [ ] Website [ ] Other \_\_\_\_\_

PATIENT DEMOGRAPHICS

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_
First Middle Last

Address \_\_\_\_\_
City State Zip

Phone \_\_\_\_\_ Email \_\_\_\_\_
Home Cell

Consent to leave pre-recorded appointment reminder calls & test results by voice message at the following phone number: \_\_\_\_\_

Race: [ ] White (Caucasian) [ ] Asian [ ] Black/African American [ ] Hispanic/Latino [ ] Native Hawaiian/Pacific Islander [ ] American Indian/Alaska Native [ ] Other
Ethnicity: [ ] Hispanic/Latino [ ] Other [ ] Refused
Marital Status: [ ] Single [ ] Married [ ] Domestic Partner [ ] Divorced [ ] Widowed [ ] Other

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_
City State Zip

Emergency Contact/Next Of Kin

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_
First Last

Does your insurance require you to use a lab other than RML? [ ] Yes [ ] No If YES, please list below \_\_\_\_\_

INSURANCE INFORMATION (Complete only if you are NOT the subscriber to the insurance.)

Primary Insurance Co. \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_
First Middle Last

Subscriber's Address \_\_\_\_\_ Phone \_\_\_\_\_
City State Zip

Subscriber's Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_
First Middle Last

Subscriber's Address \_\_\_\_\_ Phone \_\_\_\_\_
City State Zip

Subscriber's Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient or Responsible Party Signature \_\_\_\_\_

Date Signed \_\_\_\_\_