LENOX Healthcare for Women

DATE_____

PATIENT REGISTRATION FORM

NAME_____ **HOME PH**_____

ADDRESS_____ **WORK PH**_____

CITY_____**STATE**_____**ZIP**_____**CELL PH**_____

BIRTHDATE_____**SOCIAL SECURITY**_____

E-MAIL_____**Pharmacy**_____

EMERGENCY CONTACT_____**PHONE**_____

REFERRING PHYSICIAN/PRIMARY_____

EMPLOYER_____ **INSURANCE**_____

GROUP#_____ **ID#**_____

SPOUSE/PARENT_____

BIRTHDATE_____

EMPLOYER_____ **WORK PH**_____

INSURANCE_____

GROUP#_____ **SOCIAL SECURITY#** _____

The above information is correct. I hereby assign my insurance benefits directly to the physician, and I am financially responsible for non-covered services. I authorize the physician to release any information required to process this claim and for the purpose of carrying out treatment.

I,_____ hereby give my consent to Jack W. Lenox, M.D.
(Name of Patient or Authorized Agent)

to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations, all information contained in the patient record of

Signature of Patient or Parent of Minor_____

Date_____