Casper WOMEN'S CARE
Health care with a woman's touch.
(307) 237-5510
Fax: (307) 237-0607
770 East 2nd Street
Casper, WY 82601

New Patient Registration

Patient Information

Name: _____ Social Security Number: _____
Last name First Name Middle Initial

Race: _____ Ethnicity: _____

Home number:_____ Cell number:_____

Mailing Address: _____ City: _____State: _____Zip Code: _____

Age: _____ Birthday: _____ Marital Status: Single Married Separated Divorced

Email Address: _____

Preferred Method of Contact: _____ Okay to leave messages? _____

Are you employed? Yes No Place of Employment: _____

Business Address: _____ Work Phone Number: _____

If you are interested in having the ability to access your personal medical records, ask questions, refill medications, or request an appointment from our online patient portal, please provide an email address so we can send you the start-up information:

_____

Insurance Information

Do you have Medical Insurance? Yes No

Name of Primary Insurance Co.: _____

Policy ID: _____ Group Number: _____

Person Responsible for Policy: _____ Relationship to Patient: _____

Birthday: _____ Social Security Number: _____ Employer: _____

Responsible Party's Address: _____ City: _____ State: _____ Zip: _____

Responsible Party's Primary Phone Number_____ Type: Cell Home Work Other

Name of Secondary Insurance Co.:_____

Policy ID: _____ Group Number: _____

Person Responsible for Policy: _____ Relationship to Patient: _____
Birthday:_____ Social Security Number:_____ Employer:_____
Responsible Party's Address:_____ City:_____ State:_____ Zip:_____
Responsible Party's Primary Phone Number:_____ Type: Cell Home Work Other

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Patient Photo

By providing my initials, Casper Women's Care, PC has my permission to take a photograph of my face and upper body. I understand that this picture will be used as another way to identify me on my personal record and will not be used in any other manner. I also understand that Casper Women's Care, PC will not release your information except for the reason listed above: _____.
Please Initial

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____,
Name of Insurance Company
and assign all insurance benefits, if any, to Casper Women's Care, PC. I acknowledge that these benefits may be otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize the named practice to release all information necessary to secure the payment benefits. I authorize the use of my signature on all insurance submissions.
_____.
Please Initial

Financial Agreement

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature_____ Date_____

*** Please note that all agreements are valid and in effect until you have provided us with a new and/or updated agreement. ***