Asheville Obstetrics
& Gynecology

Patient Registration

Date______________________

Name ____ Name I Prefer________________
Last First Middle Maiden Name

SSN ________________________ Date of Birth _______________ Age ________ Gender: Female / Male / Other

Race ____________________________ Are you Hispanic? Yes / No Preferred Language _____________________

Address ____ City ________________ State_______ Zip ___________

Home Phone ( )______________________ Work ( )_____________________ Cell ( )______________________

Email Address____ Employer ________________________________

Marital Status ____________ Spouse/Partner's Name ____________________________ Cell ( ) ______________

Spouse/Partner Employer _____________________________________ Work Phone ( ) ____________________

Emergency Contact Name ____________________________________ Phone ( ) ___________________________

Relationship to Patient _______________________________________

Primary Care Physician ______________________________ Referring Physician ____________________________

Pharmacy Name _______________________Location/Phone____

Primary Insurance Co. _________________________Policyholder's Name __________________________________

Date of Birth __________________ SSN ___________________________ Relationship to Patient ______________

Policy # ____ Group # ___________________________________

Secondary Insurance Co. ____________________________Policyholder's Name _____________________________

Policy # ____ Group # _____________________________________

BY SIGNING, I GIVE ASHEVILLE OB/GYN PERMISSION TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

Patients Signature ____ Date _______________________

Parent/Guardian (If Minor) ____ Date _______________________