**Lifespan Physician Group, Inc.**

# REGISTRATION FORM

## PATIENT INFORMATION (PLEASE PRINT)

| Last Name | First Name | Middle | Preferred Name |
|---|---|---|---|
| | | | |

| Birth Date | Social Security # | Email |
|---|---|---|
| | | |

| Street Address | Home Phone ( ) |
|---|---|
| | |

| City | State | Zip Code | Mobile ( ) |
|---|---|---|---|
| | | | |

Marital Status (circle one)
Single / Married / Divorced / Separated / Widowed / Life Partner / Civil Union
Spouse: Name DOB

**Preferred Language**
Spoken: _____Written: _____
Interpreter Required? ❑YES ❑NO

Sex Assigned at Birth ❑Female ❑Male Gender Identity: Pronouns:
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 ( ) |
|---|---|---|---|
| | | | |

| Full Time or Part Time | |
|---|---|
| | |

Provider you are here to see today? How did you hear about us?

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

| Pharmacy | Address | Pharmacy Phone ( ) |
|---|---|---|
| | | |

## INSURANCE INFORMATION

| 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 _____ |
|---|---|---|
| | | |

Gender of Subscriber

| Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed | Subscriber's Employer |
|---|---|
| | |

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

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

Gender of Subscriber

## IN CASE OF EMERGENCY

| Name of local friend or relative to contact | Relationship to patient | Home Phone ( ) | Mobile ( ) |
|---|---|---|---|
| | | | |

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