

Women's Specialists of Clear Lake, PLLC  
Patient Registration Form (eCW)

PATIENT INFORMATION

(Please Print)

Dr.  Miss  Mr.  Mrs.  Ms.  Sir

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Previous Name \_\_\_\_\_

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell No. \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Primary Care Provider (PCP) \_\_\_\_\_ Referring Provider \_\_\_\_\_

Rendering Provider Name (this practice) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_ Sex  F - Female  M - Male  Transgender

Race  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  Black or African American  White  Declined

Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Declined

Language  English  Spanish  Indian  Japanese  Chinese  Korean  French  German  Russian  Other \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Partner

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer Name \_\_\_\_\_

Employment Status  1 - Full-Time  2 - Part-Time  3 - Not Employed  4 - Self-Employed  5 - Retired  6 - Active Military

Student Status  F - Full-Time Student  P - Part-Time Student  N - Not a Student Pharmacy Name: \_\_\_\_\_

Emergency Contact Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Pharmacy Number: \_\_\_\_\_

Phone Number \_\_\_\_\_ Do you have a living will?  Yes  No

Emergency Contact Relationship to Patient \_\_\_\_\_  Guardian

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Referring Provider Name \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

Responsible Party  Another Patient  Guarantor  Self  Check here if information is same as patient

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Guarantor Account Number \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Sex  F - Female  M - Male

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature \_\_\_\_\_ Date \_\_\_\_\_