Bella
natural women's care & family wellness

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Last Name _____ First Name _____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Date of Birth _____ Sex _____ Marital Status _____

Employers Name _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Referring Physician Name _____ Phone _____

PCP Name _____ Phone _____

Emergency Contact _____ Phone _____

Preferred Pharmacy _____ City _____ Phone _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____ Employers Name _____

Phone _____ Employer Address _____

City _____ State _____ Zip _____

Secondary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____ Employers Name _____

Phone _____ Employer Address _____

City _____ State _____ Zip _____

PLEASE SIGN BELOW

I hereby authorize providers of Bella Natural Women's Care to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

SIGNATURE OF PATIENT / AUTHORIZED PERSON _____ Date _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

SIGNATURE OF PATIENT / AUTHORIZED PERSON _____ Date _____