

# The Metropolitan Women's Group, LLC

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Date: \_\_\_\_\_ (PLEASE PRINT) Medical Record # \_\_\_\_\_

## Patient Information and Registration Form

Name \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Martial Status \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Whom may we thank for referring you \_\_\_\_\_  
In case of emergency who should we notify \_\_\_\_\_ Phone \_\_\_\_\_

## Primary Insurance Information

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Person Responsible Employed by: \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company & Address \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Name of other dependents covered under this plan \_\_\_\_\_

## Additional Insurance Information

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Subscriber employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

## Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_. And hereby authorize Metropolitan Women's Group, LLC to apply for benefits on my behalf for covered services rendered. U understand that I am financially responsible for all charges whether or not paid by insurance and further authorize the release of any necessary information to insure the payment of benefit, including medical information for this or any related claim, to the above-named billing agent, and/or the insurance named above. I authorize the use of this signature on all insurance submissions and permit a copy of this authorization to be use in place of the original.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_