

Patient Registration Form

DOWNTOWN WOMEN  
OB-GYN ASSOCIATES, LLP



568 Broadway, Suite 304 New York, NY 10012  
T: 212-966-7600 F: 212-925-8736

PATIENT LAST NAME: \_\_\_\_\_ PATIENT FIRST NAME: \_\_\_\_\_  
MIDDLE INITIAL: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ OCCUPATION: \_\_\_\_\_  
MARITAL STATUS:  Married  Single  Domestic Partner  N/A Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
COUNTRY (IF NOT U.S.A.) \_\_\_\_\_ HOME PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_  
WORK PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ X \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**\*Contact Numbers are very important in case of last minute cancellation of appointments!**

EMPLOYER NAME: \_\_\_\_\_ NOT EMPLOYED AT THIS TIME  
EMPLOYER ADDRESS AND PHONE: \_\_\_\_\_  
Are you a Full-Time Student?  Yes  No

HOW WERE YOU REFERRED TO THIS PRACTICE? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
 PHYSICIAN- DR. \_\_\_\_\_ MD's PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE PLANS: \*\*Please list your Primary and Secondary Insurance Carriers and Give Cards to the Front Desk to Copy.**

**Primary Insurance:**

PLAN NAME: \_\_\_\_\_ ID #: \_\_\_\_\_ GROUP: \_\_\_\_\_  
CLAIMS ADDRESS: \_\_\_\_\_  
PLAN PHONE #: ( ) \_\_\_\_\_ - \_\_\_\_\_ POLICY HOLDER:  SELF  SPOUSE (Complete Below)  PARENT  
SPOUSE NAME: \_\_\_\_\_ SPOUSE SOCIAL: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
SPOUSE EMPLOYER: \_\_\_\_\_ SPOUSE DOB: \_\_\_\_\_

**Secondary Insurance:**

PLAN NAME: \_\_\_\_\_ ID #: \_\_\_\_\_ GROUP: \_\_\_\_\_  
CLAIMS ADDRESS: \_\_\_\_\_  
PLAN PHONE #: ( ) \_\_\_\_\_ - \_\_\_\_\_ POLICY HOLDER:  SELF  SPOUSE (Complete Below)  PARENT  
SPOUSE NAME: \_\_\_\_\_ SPOUSE SOCIAL: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
SPOUSE EMPLOYER: \_\_\_\_\_ SPOUSE DOB: \_\_\_\_\_

**ASSIGNMENT AND RELEASE:** I, the undersigned, certify that the above information is correct and assign all payments made on my behalf by my insurance carrier(s) directly to Downtown Women OB-GYN Associates, LLC and its physicians / allied health practitioners. I hereby authorize the release of any and all information necessary to obtain payment of benefits for services provided to me. I understand that I am responsible for any and all charges not covered by my insurance carrier due to the lack of such benefits within my plan or due to my lack of coverage for any reason. I understand that I am also responsible for any co-insurances, deductibles and co-payments.

**\*\* I also acknowledge receipt of the HIPAA Notice of Privacy Practices for this practice.**

\_\_\_\_\_  
Patient Signature Relationship to Patient, if not Patient Date