Azalea Women's Center, P.C.

Patient Registration Form (Please Print)

Name: _____

Mailing Address:_____

City:_____ ST:_____ Zip:_____ Home Phone:_____ Message Phone:_____

Date of Birth:_____ Age:_____ SS#:_____ Preferred Language if other than English:_____

Race: [ ] Black [ ] White [ ]Hispanic [ ] Asian [ ] Other Gender: [ ] Female [ ] Male

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Homosexual (Lesbian/Gay) [ ] Heterosexual (Straight) [ ] Bisexual

Smoking Status: [ ] Current Every Day Smoker [ ] Current Some Day Smoker [ ] Former Smoker [ ] Never Smoker

Do you wish to enroll in our patient portal [ ] Yes [ ] No Email address:_____

Drug Allergies:_____ Pharmacy:_____

Employer: _____ Employment Status: [ ] Full time [ ] Part time

Spouse Name:_____ Spouse SS#:_____ Spouse Employer:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Primary Insurance:_____ ID/Policy #:_____Group#:_____

Policy Holder:_____
Name Date of Birth Relationship

Secondary Insurance:_____ ID/Policy #:_____ Group #:_____

Policy Holder:_____
Name Date of Birth Relationship

Please allow us to make a copy of all your health insurance cards. If we do not have your insurance card, you will be expected to pay all charges in full at the time of service. Your copay and/or coinsurance is due at time of service. For your convenience we file claims to your insurance company; however you are still financially responsible. If your claim is not paid in a timely manner the financial responsibility falls on the guarantor. Payment is due when statement is received. LAB SPECIMENS ARE SENT TO LAP CORP AND PAP SMEARS ARE SENT TO COLQUITT PATHOLOGY. IF YOU HAVE A LAB CARD PLEASE PROVIDE IT AT CHECK IN.

How did you hear about our practice? [ ]TV [ ] Yellow Pages [ ] Internet [ ] Friend [ ] Other:_____

It is our policy to call and remind you of your upcoming appointments. I prefer you contact me via:

Text at:_____ Phone at:_____ or Email at:_____

Consent for Treatment/Assignment of Benefits

I hereby give consent to all medical care that J. Michael Sharon, MD, associates, or designees may deem necessary or advisable during my visit. **I understand that I have the right to refuse treatment at any time.** I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to Azalea Women's Center, PC. and all physicians, associates, assistants, or designees that may provide services to me.

Patient or Guardian Signature:_____ Date:_____