Vermont Urogynecology Associates, PC

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PATIENT REGISTRATION FORM

PATIENT INFORMATION:

LAST NAME_____ FIRST NAME _____

MAILING ADDRESS_____ CITY_____ STATE____ ZIP_____

HOME PHONE_____ CELL PHONE_____

SOC. SEC._____ DATE OF BIRTH_____ SEX: M or F

MARITAL STATUS_____ WHO ARE YOU HERE TO SEE?_____

REFERRING PROVIDER _____

PRIMARY CARE PROVIDER _____

Payment Policy for Services Rendered:

PRIMARY INSURANCE: _____ POLICY #:_____

SECONDARY INSURANCE: _____ POLICY#:_____

"I understand and agree that regardless of my insurance, I am in the end responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and the practice of Vermont Urogynecology incurs collection charges, they will be my responsibility."

Patient Signature: _____ Date: _____