

**PUTNAM GYNECOLOGY & OBSTETRICS OF GREENWICH, P.C.**  
**PATIENT REGISTRATION FORM**

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Init: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please fill in all that apply and number your preference (i.e. 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup>).

\_\_\_\_\_ Home Phone: (     ) \_\_\_\_\_  Do  Do Not Leave a message on my answering machine or with any other person

\_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_ Other: (     ) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single / Married / Other Maiden Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. No: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Allergies: \_\_\_\_\_

How did you hear about our practice: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**PRIMARY INSURANCE**

Subscriber: \_\_\_\_\_ Policy Owner's Employer's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Self/Spouse/Child/Other DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer's Address: \_\_\_\_\_

Carrier: \_\_\_\_\_

ID Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

**AUTHORIZATIONS**

I HEREBY AUTHORIZE YOU TO CONTACT ME TO CONFIRM APPOINTMENTS, TO COMMUNICATE INFORMATION RELATED TO MY PERSONAL HEALTH AND TREATMENT, AND FOR PURPOSES OF OBTAINING PAYMENT.

I HEREBY GIVE PUTNAM GYNECOLOGY & OBSTETRICS OF GREENWICH PERMISSION TO SPEAK TO A FAMILY MEMBER/SIGNIFICANT OTHER REGARDING MY PERSONAL HEALTH AND TREATMENT.

PLEASE SPECIFY PERSON(S) \_\_\_\_\_

I HAVE RECEIVED OR HEREBY ACKNOWLEDGE THAT I AM ENTITLED TO RECEIVE A COPY OF THE MEDICAL PRACTICE'S *NOTICE OF PRIVACY PRACTICES*. I FURTHER ACKNOWLEDGE THAT A COPY OF THE CURRENT *NOTICE OF PRIVACY PRACTICES* WAS POSTED IN THE RECEPTION AREA AND I AM AWARE THAT I MAY REQUEST A COPY OF ANY AMENDED *NOTICE OF PRIVACY PRACTICES* AT EACH APPOINTMENT OR IN WRITING.

I AUTHORIZE PAYMENT OF MEDICAL AND SURGICAL BENEFITS TO PUTNAM GYNECOLOGY AND OBSTETRICS OF GREENWICH, P.C. FOR ANY SERVICES FURNISHED ME BY THIS OFFICE.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME, TO RELEASE TO THE INSURANCE COMPANY AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS FOR RELATED SERVICES.

I AGREE TO PAY PUTNAM GYNECOLOGY AND OBSTETRICS OF GREENWICH, P.C. ANY AND ALL CHARGES NOT PAID BY INSURANCE BENEFITS. IF MY ACCOUNT IS NOT PAID, I WILL PAY ALL COURT COSTS, ATTORNEY'S FEES, AND OTHER COSTS INCURRED BY PUTNAM GYNECOLOGY AND OBSTETRICS OF GREENWICH, P.C. TO COLLECT THE BALANCE DUE.

Signed: \_\_\_\_\_  
(Patient, Legal Guardian, or Parent is under 18 years of age)

Date: \_\_\_\_\_