Casper Women's Care, PC

770East 2ND Street
Casper WY, 82601
Phone: 307-237-5510
Fax: 307-237-0607

New Patient Registration

Patient Information

Name: ____ Social Security Number: ______________________
Last name First Name Middle Initial

Race: _________________________________ Ethnicity: ____

Home number:_________________________ Cell number:____

Mailing Address: _____________________________ City: _________State: _____Zip Code: ___________________

Age: _________ Birthday: ___________ Marital Status: Single Married Separated Divorced

Preferred Method of Contact: ________________________________ Okay to leave messages? _________________

Are you employed? Yes No Place of Employment: ____

Business Address: ______________________________________ Work Phone Number: ______________________

As of July 1st, 2016 you have the ability to access your personal medical records, ask questions, refill medications, or request an appointment from our online patient portal, and avoid paperwork to be done in our office; please provide an email address so we can send you the start-up information:

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Insurance Information

Do you have Medical Insurance? Yes No PLEASE COMPLETE EVEN IF WE GOT A COPY OF YOUR CARD!

Name of Primary Insurance Co.: ____

Policy ID: _______________________________________ Group Number: ________________________________

Person Responsible for Policy: _____________________________ Relationship to Patient: ____________________

Birthday: _____________ Social Security Number: ____________________ Employer: _______________________

Responsible Party's Address: ___________________________ City: _____________ State: ________ Zip: _________

Responsible Party's Primary Phone Number_____________________________ Type: Cell Home Work Other

Name of Secondary Insurance Co.:____

Policy ID: _______________________________________ Group Number: ________________________________

Person Responsible for Policy: _____________________________ Relationship to Patient: ____________________

Birthday:______________ Social Security Number:___________________ Employer:_________________________

Responsible Party's Address:_____________________________ City:___________ State:_____________ Zip:________

Responsible Party's Primary Phone Number:____________________________ Type: Cell Home Work Other

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Patient Photo

By providing my initials, Casper Women's Care, PC has my permission to take a photograph of my face and upper body. I understand that this picture will be used as another way to identify me on my personal record and will not be used in any other manner. I also understand that Casper Women's Care, PC will not release your information except for the reason listed above: _________________________.
Please Initial

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ________________________________,
Name of Insurance Company
and assign all insurance benefits, if any, to Casper Women's Care, PC. I acknowledge that these benefits may be otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize the named practice to release all information necessary to secure the payment benefits. I authorize the use of my signature on all insurance submissions.
_______________________.
Please Initial

Financial Agreement

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature____ Date______________________________________

*** Please note that all agreements are valid and in effect until you have provided us with a new and/or updated agreement. ***