Gateway Obstetrics & Gynecology
REGISTRATION FORM

Today's Date:

Dr. Darshna Chandrasekhara

PATIENT INFORMATION

Patient's last name: First: Middle: Marital status:

Is this your legal name? If not, what is your legal name? Former name: Birth date: Age: Sex:

☐ Yes ☐ No [Age] ☐ M ☐ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.: Home phone no.: Cell phone no.:

Occupation: Employer: Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option): ☐ Referral Doctor's name _____

☐ Reason _____

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.:

Is this person a patient here? ☐ Yes ☐ No Is this patient covered by insurance? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment:

Patient's relationship to subscriber: [] Self [] Spouse [] Child [] DP

Pharmacy Name: Pharmacy Address: Pharmacy Tele Number:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gateway Obstetrics & Gynecology or insurance company to release any information required to process my claims.

Patient/Guardian signature Date