

Premier Women's Healthcare, LLC

**5900 Hillandale Dr.
Annex A
Lithonia, Ga 30058
(678) 418-6990 Office
(678) 418-6986 Fax**

REGISTRATION
(PLEASE PRINT)

Date: _____

PATIENT REGISTRATION

Last name _____, First name _____, Middle Initial _____

Address _____ City _____ St _____ Zip _____

D.O.B. _____ E-mail _____ SS# _____

Home Phone () _____ Cell Phone () _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School # _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone # _____

PRIMARY INSURANCE

Person Responsible for Account _____

Relation to Patient _____ Birth Date _____ SS# _____

Address (if different from patient's) _____ City _____

State _____ Zip Code _____

Person Responsible Employed by _____

Occupation _____ Business Phone () _____

Insurance Company _____

Contract # _____ Group # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____ Yes or No

Subscriber Name _____ Birth Date _____

Relation to Patient _____

Address (if different from patient's) _____

Subscriber Employed by: _____ Business Phone () _____

Insurance Company _____ SS # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____

and assign directly to Dr. Dominique Smith all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services.

Signature of Patient, Guardian, or Personal Representative Date

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