WHC
WOMEN'S HEALTH CONSULTANTS

REGISTRATION FORM (Please print and COMPLETE all entries)

NAME: LAST	FIRST	MAIDEN NAME	DOB	AGE
STREET ADDRESS	☐ SINGLE ☐ DIVORCED	☐ MARRIED ☐ WIDOWED	SOCIAL SECURITY NO.	
CITY	STATE	ZIP	DRIVER'S LICENSE NO.	
HOME PHONE NO.	CELL PHONE	EMAIL ADDRESS		

EMPLOYER	OCCUPATION
STREET ADDRESS	ARE YOU A STUDENT? YES ☐ NO ☐ ☐ FULL TIME ☐ PART TIME
CITY STATE ZIP	EMPLOYER'S PHONE NO.
SPOUSE'S NAME	SOCIAL SECURITY NO. DOB
SPOUSE'S EMPLOYEER	SPOUSE'S EMPLOYEER PHONE NO
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN
STREET ADRRESS	STREET ADDRESS
CITY STATE ZIP	CITY STATE ZIP
PHONE NO. FAX NO.	PHONE NO. FAX NO.
PRIMARY INSURANCE NAME GROUP NO.	I.D. NO PHONE NO
STREET ADDRESS	NAME OF INSURED RELATIONSHIP/DOB
CITY	STATE ZIP
SECONDARY INSURANCE NAME GROUP NO.	I.D. NO. PHONE NO.
STREET ADDRESS	NAME OF INSURED RELATIONSHIP/DOB
CITY	STATE ZIP

NEAREST RELATIVE NOT LIVING WITH YOU	RELATIONSHIP RELATIVE'S PHONE NO.
IN CASE OF EMERGENCY, NOTIFY	EMERGENCY CONTACT'S PHONE NO.

SIGNATURE: _____ DATE: _____

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent Women's Health Consultants may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Women's Health Consultants Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Women's Health Consultants reserves the right to revise it Notice of Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Women's Health Consultants Privacy Officer at 58 E. Walton St, Floor 3, Chicago, IL 60611.

With my consent Women's Health Consultants may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that Women's Health Consultants restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Women's Health Consultants' use and disclosure of my PHI to carry out TPO.

Home:_____
_____

Other:_____
_____

I may revoke my consent in writing except to the consent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Women's Health Consultants may decline to provide treatment to me.

I hereby acknowledge receipt of the Notice of Privacy Practices:

Patient's Name: _____ DOB: _____

Patient's Signature _____ Date: _____

If this acknowledgement is by someone other than the patient (personal representative).

Personal Representative's Name: _____

Personal Representative's Signature: _____

Relationship to Patient: _____ Date:_____

With my consent Women's Health Consultants may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments, reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Home: _____ OK to Call: ☐/☐ Voice Mail Messages ☐/☐

Cell : _____ OK to Call: ☐/☐ Voice Mail Messages ☐/☐