CANTON WOMEN'S CENTER
REGISTRATION

Name: _____ **"Nick Name":** _____
Last First MI

Address: _____ **Date of Birth:** _____
Street PO Box

_____ **Social Security #:** _____
City State Zip

Home Phone: _____ **Family Physician:** _____

Cell Phone: _____ **E-Mail Address:** _____

Employer: _____ **Work Phone:** _____

Work Address: _____

Occupation: _____ **Marital Status:** _____

Husband's Name: _____ **His Social Security #:** _____

His Employer: _____ **His Occupation:** _____

His Work Phone: _____ **His Date of Birth:** _____

Person Responsible for Account: _____
Name Relationship

Primary Insurance: _____ **Insured's Name:** _____

Secondary Insurance: _____ **Insured's Name:** _____

Who should be notified in an emergency:_____
Name Relationship Phone

Nearest relative not living with you: _____
Name Relationship Phone

Known Medical Problems: _____

Known Allergies: _____

How did you learn about the Canton Women's Center?_____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

_____ _____/_____/_____
Signature (Patient or Representative) **Date**

Revised 01/2020