Veronica Socas, M.D
Bradenton Women's Care

NEW PATIENT REGISTRATION

Today's Date_____

LAST NAME_____ FIRST_____ MI____ MAIDEN NAME_____

Address:_____ SUITE/APT_____ City_____ State____ Zip_____
DOB:_____ Gender: F or M Social Security #_____

Email:_____ Marital Status: Single Married Widowed Separated Divorced

Phone (_____)_____ Cell (____)_____ Work (____)_____

Employer:_____ Ethnicity: Caucasian / African American / Hispanic/ Asian / Other

REMINDERS: Preferred Follow Up Method: Email _____Text Msg _____Voice Msg _____

Emergency Contact Name _____Relationship to patient:_____
Emergency Contact's Phone #_____

Responsible Party/Guarantor (***Complete if someone other than yourself is legally responsible for you or your bills***.)
Name:_____
Relationship to Patient: _____
Address:_____ City:_____
State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____SSN#_____

Insurance Information

Primary Carrier:_____Policy#_____Group#_____

Name of Insured_____ DOB:_____ Social Security #_____

Address:_____ SUITE/APT_____ City_____ State____ Zip_____

DOB:_____ Gender: F or M Relationship to patient:_____

Secondary Carrier:_____Policy#_____Group#_____

Name of Insured_____ DOB:_____ Social Security #_____

Address:_____ SUITE/APT_____ City_____ State____ Zip_____

DOB:_____ Gender: F or M Relationship to patient:_____

I understand that payment is due at time service is rendered. I hereby authorize the release of any medical information to my insurance company and any physicians involved in my care. I realize this authorization allows Bradenton Women's Care to release my medical records as stated above. I hereby assign all MEDICAL and/or SURGICAL benefits that are paid by any insurance carrier on my behalf, or that I am entitled to have paid, to Bradenton Women's Care. I understand that Bradenton Women's Care does not extend credit. I acknowledge and understand that insurance is filed as a courtesy and any contract with regard to insurance is between me nd the carrier. I understand that in the event my account is turned over for collection, I may incur and am responsible for any additional fees or costs associated with collection of my account. SIGNED:_____ DATE:_____

Bradenton Women's Care

Phone: 941-761-1111 Fax: 941-761-1122

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or have been offered and declined, a copy of the Notice. A current copy of the Notice is also posted in the office, on our website and is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time. *You may decline to sign this acknowledgement.*

Please help us to protect your privacy by answering the following questions:

1. How did you hear about us? □ A friend/family member □ Hospital □ Our Website □ Insurance company

□ Other _____

2. May we obtain your medication history from your pharmacy? □ Yes □ No

3. Can we leave a detailed message on your voice mail? □ Yes □ No

*If you only have a cell phone, and choose to not get messages, you **WILL NOT** get any automatic calls,

including appointment reminder calls.

4. Which phone number would you like us to use? □ Home □ Cellular □ Work

5. Can we release information to anyone other than you? □ Yes □ No

6. Please list each person and indicate which permissions are allowed.

(NOTE: We will NOT release any information to anyone that is not listed here.)

Name: _____

Relation: _____ □ Records □ Financials □ Samples

Name: _____

Relation: _____ □ Records □ Financials □ Samples

I have □ **RECEIVED** □ **DECLINED** a complete copy of the "Notice of Privacy Practices." This is to verify that I have read and understand the above information. By signing this statement, I am giving Bradenton Women's Care and its staff permission to release my personal information as described above.

_____ _____

Signature of Patient Date

For Patients Under Age 18

In addition to the above information, I authorize Bradenton Women's Care, LLC to diagnose and

provide medical treatment for:

_____ _____ _____

Patient Name Signature of Guardian Date

For Office Use Only:

We were unable to obtain this written acknowledgement. _____ _____

Employee Initials Date

Notes_____