



**New Patient Registration**

Your name-\_\_\_\_\_ Date of birth-\_\_\_\_\_  
Social Security Number-\_\_\_\_\_ e-mail address \_\_\_\_\_  
Street Address \_\_\_\_\_  
City-\_\_\_\_\_ State-\_\_\_\_\_ Zip Code-\_\_\_\_\_  
Home phone-\_\_\_\_\_ C ell Phone-\_\_\_\_\_ Business Phone-\_\_\_\_\_  
Occupation-\_\_\_\_\_ Employers Name and Address-\_\_\_\_\_  
Marital Status-\_\_\_\_\_ Referred by-\_\_\_\_\_  
Person to notify in an emergency-\_\_\_\_\_ Phone-\_\_\_\_\_  
Primary care physician-\_\_\_\_\_ Can we reach you at- home work cell

Name of Insurance Company-\_\_\_\_\_ Address-\_\_\_\_\_  
Policy Number-\_\_\_\_\_ Group Number-\_\_\_\_\_ Effective Date-\_\_\_\_\_  
Policyholders Name-\_\_\_\_\_ Date of Birth-\_\_\_\_\_

Financial Responsible Party-\_\_\_\_\_ Relationship to Patient-\_\_\_\_\_  
Street Address \_\_\_\_\_  
City-\_\_\_\_\_ State-\_\_\_\_\_ Zip Code-\_\_\_\_\_  
Home phone-\_\_\_\_\_ C ell Phone-\_\_\_\_\_ Business Phone-\_\_\_\_\_  
Occupation-\_\_\_\_\_ Employers Name and Address-\_\_\_\_\_

*I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.*

*I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.*

*A finance fee of 12% per annum will be added to any balance over 60 days old. I authorize and request that insurance payments be made directly to Blue Ridge OB/GYN should they elect to receive such payment.*

Date-\_\_\_\_\_ Signature-\_\_\_\_\_