The Miriam Hospital - Women's Medicine Collaborative
146 West River Street, Providence, RI 02904

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone ( )

City	State	Zip Code	Alternate Phone ( )

Marital Status (circle one) Single / Married / Divorced / Separated / Widowed / Life Partner / Civil Union	**Preferred Language** Spoken: _____ Written: _____ Interpreter Required? ❑YES ❑NO

Sex: ❑Female ❑Male Religion:

Race (circle one): American Indian / Alaskan Native / American Indian & Native Hawaiian / Asian / Asian & America Indian / Asian & Native Hawaiian / Black & Asian/ Black & American Indian / Black & Native Hawaiian / Black-African American / White / White & American Indian / White & Asian / White & Black / White & Native Hawaiian / Other **Hispanic/Latino (circle one):** Hispanic / Non-Hispanic

Are you Employed? ❑YES ❑ NO	Employer	Occupation	Employer Phone ( )

How did you hear about us?

Provider you are here to see today?

Primary Care Provider (PCP)/Practice Name

PCP Address	PCP Phone ( )

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No	Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Subscriber's Employment Status ❑Full Time ❑ Part Time ❑Unemployed	Subscriber's Employer

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Alternate Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (WMC) or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

Would you like access to the Women's Medicine Collaborative Patient Portal? ❑Yes ❑No

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑Yes ❑No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ❑Yes ❑No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑Yes ❑No