Salina Women's Clinic
Salina Regional Health Center

Dr. Merle J. "Boo" Hodges, M.D.
Dr. Christopher R. Graber, M.D.

501 S. Santa Fe • Suite 140
Salina, KS 67401
Phone: (785) 827-7996 • Fax: (785) 825-4490

REGISTRATION FORM

Date:_____

PATIENT INFORMATION

Patient Name:_____ Age:_____Sex:_____
First MI Last

Mailing Address:_____

City:_____State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Birth Date:_____ SSN:_____

____Single ____Married ____Widowed ____Divorced ____Other:_____

Referring Physician:_____ Primary Physician:_____

Email Address:_____

EMPLOYMENT

___Full-time ____Part-time ____Retired ____Self-Employed ____Unemployed ____Disabled ____Minor

Employer: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____ (Ext:)

PERSON RESPONSIBLE FOR BILL

____Same as Patient ____Parent/Guardian ____Other_____
(If other than patient please fill in the following information)

Name:_____SSN:_____

Address:_____Phone Number:_____

City:_____State:_____Zip:_____Birth Date:_____

___Full-time ____Part-time ____Retired ____Self-Employed ____Unemployed ____Disabled

Employer:_____

Address:_____

City:_____ State: _____ Zip:_____ Phone: _____(Ext:)

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Patient Name: _____ **Patient DOB**: _____

INSURANCE

Primary Insurance:_____
Policy Holder: Same as Patient ____Spouse ____Parent/Guardian ____Other: _____
(If other than the patient please fill in the following information)
Name of Insured (policy holder):_____

Policy Number:_____ Group Number:_____

Address of Insured:_____

City:_____ State:_____Zip:_____

Home Phone:_____ Other Phone:_____

DOB of Insured:_____ SSN of Insured:_____ Sex of Insured:_____
___Full-time ____Part-time ____Retired ____Self-Employed ____Unemployed ____Other:_____

Employer:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____ (Ext:)

Secondary Insurance:_____
Policy Holder: Same as Patient ____Spouse ____Parent/Guardian ____Other: _____
(If other than the patient please fill in the following information)
Name of Insured (policy holder):_____

Policy Number:_____ Group Number:_____

Address of Insured:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Other Phone:_____

DOB of Insured:_____ SSN of Insured:_____ Sex of Insured:_____
___Full-time ____Part-time ____Retired ____Self-Employed ____Unemployed ____Other:_____

Employer:_____

Address:_____

City:_____State:_____Zip:_____Phone:_____(Ext:)

We cannot file insurance without a copy of your insurance cards for verification of coverage. (See next page for signature)

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Patient Name: _____ Patient DOB: _____

EMERGENCY INFORMATION

Next of Kin:_____ Phone Number:_____

Relationship to patient: ____Spouse ____Parent/Guardian ____Other_____

____Address is same as patient ____Different address (please fill in the following information)

Address:_____

City:_____ State:_____ Zip:_____

Nearest friend of relative (outside the home):_____

Address:_____

City:_____ State:_____ Zip:_____

Relationship to patient:_____ Phone Number:_____

I hereby authorize my provider to furnish my insurance company or its representative or permit my insurance companyor its representative to review any information requested with respect to any illness or accident, medical history or copiesof hospital and medical records. A Photostatic copy of this authorization shall be considered as valid as the original. I herebyauthorize payment directly to my provider for this illness or injury, of the provider's benefits otherwise payable to me, but notto exceed my indebtedness to said provider. I agree to pay the provider for all my charges whether or not covered by this assignment. The responsible party herby agrees that the provider's office or the party responsible for the billing of these servicesmay check information needed to determine these benefits payable for related services. This release may include information which may be considered a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).
I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. I have been notified that I may receive service from the Nurse Practitioner or Physician Assistant at this location.

PLEASE NOTE: The patient portion of the bill is due at the time of service unless prior arrangements have been made.

_____ _____
Patient or Authorized Person's Signature Date/Time

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DATE: _____

NAME: _____ DOB: _____

I hereby give you (Salina Women's Clinic) permission to disclose any Medical/Health information deemed necessary to the below listed individuals. I realize that I may revoke this at any time. This information will be kept confidential to all others.

My health information may be given to:

Name	Relationship	Date

As of this date my pharmacy of choice is:

_____

I hereby give Salina Women's Clinic permission to leave messages on my voicemail or home answering machine:

Approve: _____ Deny: _____

Signature: _____

Date: _____

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DATE: _____

PATIENT NAME:_____DOB:_____

Medication List

Medication Name	Dose	How often are you taking?	What is the medication for?	Reviewed date

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AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Requesting records/information from: _____

_____

DATE: _____

PATIENT NAME:_____DOB:_____

Social Security Number: _____

Purpose for release (please check all that apply):

_____ Transfer of care _____ Insurance request

_____ Other (please explain): _____

Information requested: _____

Dates of records requested: _____

Other: _____

Release records/information to: _____

_____

This authorization will expire one year from the date above.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

Signature of patient, legal guardian, or representative: _____

Witness: _____ Date:_____