Gold Coast Gynecology
Randall M. Toig, MD

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NUMBER					
FIRST NAME & INITIAL		LAST NAME			
ADDRESS LINE 1					
ADDRESS LINE 2					
CITY		STATE		ZIP	
HOME PHONE		E-MAIL			
DATE OF BIRTH		SEX		MARITAL STATUS (M/S)	
REFERRED BY		DOCTOR		DOES YOUR INSURANCE COMPANY REQUIRE PRE-AUTHORIZATION? (Y/N)	
PATIENT S.S. NO.					
PATIENT'S EMPLOYER					
EMPLOYER ADDRESS					
CITY		STATE		ZIP	
EMPLOYER PHONE		EXT			

GUARANTOR

RESPONSIBLE PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP	
ADDRESS					
CITY		STATE		ZIP	
PHONE		RESPONSIBLE PARTY S.S. NO.			
RESPONSIBLE PARTY EMPLOYER					
EMPLOYER ADDRESS		EMPLOYER PHONE			

INSURANCE INFORMATION

1	INSURANCE #1 NAME					
	INSURANCE #1 ADDRESS		INS. #1 PHONE			
	POLICYHOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
	CERTIFICATE NO.		GROUP NO.		MEMBER NO.	
2	INSURANCE #2 NAME					
	INSURANCE #2 ADDRESS		INS. #2 PHONE			
	POLICYHOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
	CERTIFICATE NO.		GROUP NO.		MEMBER NO.	
3	INSURANCE #3 NAME					
	INSURANCE #3 ADDRESS		INS. #3 PHONE			
	POLICYHOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
	CERTIFICATE NO.		GROUP NO.		MEMBER NO.	
	SPOUSE'S NAME		SPOUSE'S S.S. NO.		SPOUSE'S WORK PHONE	
	NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE			

SIGNATURE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services.	SIGNATURE (Patient or Parent if Minor)	DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.	SIGNATURE	DATE