

WOMEN & INFANTS  
BREAST HEALTH CENTER

668 Eddy Street | 2nd Floor | Providence, RI 02905-2499  
(401) 453-7540

PATIENT REGISTRATION

ALL AREAS MUST BE COMPLETED

6083-20.25 (11-2020)

| PERSONAL INFORMATION  |  |                                    |   |          |                     |  |                           |       |                              |  |  |      |  |
|---|--|------------------------------------|---|----------|---------------------|--|---------------------------|-------|------------------------------|--|--|------|--|
| PATIENT NAME (LAST)   |  |                                    | (FIRST)   |          | (MI)                |  | OCCUPATION                |       |                              |  |  |      |  |
| MAIDEN NAME (IF APPLICABLE) /OPTIONAL STREET ADDRESS  |  |                                    |   |          |                     | EMPLOYER NAME  |                           |       |                              |  |  |      |  |
| STREET ADDRESS (MAILING)  |  |                                    |   |          |                     | EMPLOYER PHONE (INCLUDE AREA CODE)                       |                           |       |                              |  |  |      |  |
| CITY  |  | STATE                              |   | ZIP CODE |                     | STREET ADDRESS   |                           |       |                              |  |  |      |  |
| HOME PHONE (INCLUDING AREA CODE)  |  | MOBILE PHONE (INCLUDING AREA CODE) |   |          |                     | CITY   |                           | STATE |                              | ZIP CODE   |  |      |  |
| EMAIL ADDRESS   |  |                                    |   |          |                     | EMERGENCY CONTACT  |                           |       | RELATIONSHIP                 |  |  |      |  |
| GENDER IDENTITY   |  |                                    |   |          |                     | STREET ADDRESS   |                           |       |                              |  |  |      |  |
| DATE OF BIRTH   |  |                                    |   | AGE      |                     | CITY   |                           | STATE |                              | ZIP CODE   |  |      |  |
| M   |  |                                    |   | D        |                     | Y  |                           |       |                              |  |  |      |  |
| MARITAL STATUS  |  |                                    |   |          |                     | HOME PHONE NUMBER (INCLUDING AREA CODE)                  |                           |       | MOBILE (INCLUDING AREA CODE) |  |  |      |  |
| M   |  |                                    |   |          |                     | S  |                           | D     |                              | W  |  |      |  |
| SOCIAL SECURITY NUMBER  |  |                                    |   |          |                     | DID YOU RECEIVE PRIVACY POLICY FORM?                     |                           |       | DATE                         |  |  |      |  |
|   |  |                                    |   |          |                     | <input type="checkbox"/> YES <input type="checkbox"/> NO |                           |       | / /                          |  |  |      |  |
| RACE  |  | ETHNICITY                          |   |          |                     |  |                           |       |                              |  |  |      |  |
| PRIMARY CARE PHYSICIAN  |  |                                    |   |          | REFERRING PHYSICIAN |  |                           |       |                              |  |  |      |  |
| NAME (LAST)   |  |                                    | (FIRST)   |          | (MI)                |  | NAME (LAST)               |       |                              | (FIRST)  |  | (MI) |  |
| STREET ADDRESS  |  |                                    |   |          |                     | STREET ADDRESS   |                           |       |                              |  |  |      |  |
| CITY  |  | STATE                              |   | ZIP CODE |                     | CITY   |                           | STATE |                              | ZIP CODE   |  |      |  |
| PHONE NUMBER (INCLUDE AREA CODE)  |  |                                    |   |          |                     | PHONE NUMBER (INCLUDE AREA CODE)                         |                           |       |                              |  |  |      |  |
| HEALTH INSURANCE  |  |                                    |   |          |                     |  |                           |       |                              |  |  |      |  |
| HEALTH INSURANCE  |  |                                    | SUBSCRIBER INFORMATION                            |          |                     |  | IDENTIFICATION NO.        |       |                              |  |  |      |  |
| PRIMARY COMPANY NAME  |  |                                    | SUBSCRIBER NAME                                   |          |                     |  | CERTIFICATE NO.           |       |                              |  |  |      |  |
|   |  |                                    | DATE OF BIRTH                                     |          |                     |  | GROUP NO. / NAME          |       |                              |  |  |      |  |
| ADDRESS   |  |                                    | SOCIAL SECURITY NUMBER                            |          |                     |  | SUBSCRIBER EMPLOYER       |       |                              |  |  |      |  |
|   |  | PHONE (INCLUDE AREA CODE)          | PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) |          |                     |  | SUBSCRIBER EMPLOYER PHONE |       |                              | <input type="checkbox"/> FULL TIME<br><input type="checkbox"/> PART TIME |  |      |  |
|   |  |                                    | 1 SELF  | 2 SPOUSE | 3 CHILD             | 4 OTHER  |                           |       |                              |  |  |      |  |
| SECONDARY COMPANY NAME  |  |                                    | SUBSCRIBER NAME                                   |          |                     |  | CERTIFICATE NO.           |       |                              |  |  |      |  |
|   |  |                                    | DATE OF BIRTH                                     |          |                     |  | GROUP NO. / NAME          |       |                              |  |  |      |  |
| ADDRESS   |  |                                    | SOCIAL SECURITY NUMBER                            |          |                     |  | SUBSCRIBER EMPLOYER       |       |                              |  |  |      |  |
|   |  | PHONE (INCLUDE AREA CODE)          | PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) |          |                     |  | SUBSCRIBER EMPLOYER PHONE |       |                              | <input type="checkbox"/> FULL TIME<br><input type="checkbox"/> PART TIME |  |      |  |
|   |  |                                    | 1 SELF  | 2 SPOUSE | 3 CHILD             | 4 OTHER  |                           |       |                              |  |  |      |  |
|   |  |                                    | SUBSCRIBER NAME                                   |          |                     |  | CERTIFICATE NO.           |       |                              |  |  |      |  |
|   |  |                                    | DATE OF BIRTH                                     |          |                     |  | GROUP NO. / NAME          |       |                              |  |  |      |  |
| ADDRESS   |  |                                    | SOCIAL SECURITY NUMBER                            |          |                     |  | SUBSCRIBER EMPLOYER       |       |                              |  |  |      |  |
|   |  | PHONE (INCLUDE AREA CODE)          | PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) |          |                     |  | SUBSCRIBER EMPLOYER PHONE |       |                              | <input type="checkbox"/> FULL TIME<br><input type="checkbox"/> PART TIME |  |      |  |
|   |  |                                    | 1 SELF  | 2 SPOUSE | 3 CHILD             | 4 OTHER  |                           |       |                              |  |  |      |  |
| EXTENDED AUTHORIZATION AND CONSENT  |  |                                    |   |          |                     |  |                           |       |                              |  |  |      |  |
| I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services provided on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this or a related Medicare or insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original. |  |                                    |   |          |                     |  |                           |       |                              |  |  |      |  |
| SIGNATURE OF PATIENT<br>OR AUTHORIZED REPRESENTATIVE  |  |                                    | X   |          |                     | DATE / /   |                           |       |                              |  |  |      |  |