El Camino Women's Medical Group

Obstetrics, Gynecology, Infertility & Minimally Invasive Surgery

Registration Form

Personal information

First name: MI: Last name:
SSN: DOB: Driver's license:

Address:
City: State: Zip code:
Phone (H): Phone (Cell):
Email: Educational level:

Marital status:
Preferred language: Ethnicity (may list multiple):
Preferred pharmacy: Pharmacy Address/Phone:
Primary care physician: May we send them your visit summaries?
Referred by: ☐ Yes ☐ No

Employment information

Employer: Occupation:

Emergency contact

Name: Relationship: Phone:

Insurance information

Insurance company: Insurance type: ☐ PPO/EPO ☐ POS ☐ HMO
Insured person's name: Insured person's DOB:
Group number: Subscriber ID number:

Privacy preferences

I request the following restrictions to the use or disclosure of my health information:

Medical information can only be discussed with:

☐ Patient only ☐ Family member/friend: _____
☐ Physician ☐ Other_____

Detailed messages regarding test results can be left on voicemail:

☐ No ☐ Yes, at this number: _____

Any updated/amended copies of this office's notice of Privacy Practices will be sent to your listed email address, unless otherwise requested. The most updated policies will always be available in the office and on the website: www.ElCaminoWomen.com.