PACIFIC PERINATAL CENTER
*Dedicated to specialized & highly personalized pregnancy care*

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# NEW PATIENT REGISTRATION

Patient Name (Last) _____ (First) _____ (MI) _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Cellphone _____ Email _____

Patient's Employer _____ Occupation _____ Marital Status: ❒Married ❒Single ❒Divorced ❒Widowed

Social Security # _____ Who may we thank for referring you: ❒Physician ❒Friend ❒Website ❒Other _____

Emergency Contact _____ Relationship _____ Address _____ Telephone _____

Spouse's Name _____ Date of Birth _____ Social Security # _____

Spouse's Employer _____ Occupation _____ Address _____ Telephone _____

## INSURANCE INFORMATION

Name of Primary Insurance Carrier _____ Group # _____ Policy # _____

Insured's Name _____ ID Number _____ Effective Date _____ Termination Date _____

## INSURANCE AUTHORIZATION, MEDICAL RECORD ASSIGNMENT, AND APPOINTMENT SCHEDULING

It is your responsibility to understand the terms and requirements of your insurance plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Regarding insurance plans where we are a participating provider, you are responsible for supplying our staff with your current insurance card prior to seeing the doctor. If you do not have your card, you will be required to pay for the visit in full, at the time of service. Your co-pays and deductibles will, likewise, be due at the time of service. Please be aware that some of the services provided may not be covered by your medical insurance. You will be responsible for any remaining amount owed. In the event that we are not a participating provider with your insurance carrier, we require that you pay the balance in full at the time of the visit.

Regarding my medical records, I hereby authorize release of any medical information necessary to process any insurance claims with my insurance company and assign benefits to C. Scott Naylor, MD for all payments or medical services rendered to myself. I understand that I am responsible for all fees regardless of insurance coverage, and I understand that I am responsible for any deductibles, co-insurance, or amounts for services not covered by the insurance carrier. I further authorize release of all pertinent medical records to C. Scott Naylor, MD, Inc, necessary for diagnostic evaluation and continuing medical treatment.

Regarding my scheduled appointments, the office kindly asks for at least 24-hour advance notice to cancel or reschedule an appointment. I hereby acknowledge that any missed appointments, same day cancellations, or same day rescheduling will be subject to a $30 charge.

_____ _____

Signature Date