COLUMBIA UNIVERSITY MEDICAL CENTER

Department of Obstetrics & Gynecology
Patient Registration Form
Forma de Registracion

Race *Raza*: ____________________
Ethnicity *Origen étnico*: ________________
Religion *Religión*: ________________

Last Name: ______________________ First Name: ______________________ Middle Initial: _____
Apellido *Nombre* *Inicial Media*

Date of Birth: _____/_____ /________ Martial Status: ☐ Married ☐ Single ☐ Domestic Partner ☐ N/A
Fecha de Nacimiento: *Casada* *Soltera* *Compañero Domestico*

Address: ____ Apt #______________
Direccion *Apartamento#*

City: ____________________ State: _______ Zip____________ Country (if not USA) ______________
Ciudad *Estado* *Codigo Postal* *Pais*

Home Phone: (_____) ____________ Cell: (______) ____________ Work: (_____) ____________
Telefono *Celular* *Trabajo#*

Email Address: ______________________
Direccion de correo electronico

Emergency Contact: __________________ Relationship: __________ Phone #: (____) __________
Contacto de Emergencia *Relacion:* *Telefono#*

Employer Name: ____ Not employed at this time ☐
Nombre de Empleador

Who referred you to this practice? ______________________________________
Quien los Recomendo?

Referring Physician's Name: __________________Phone #: _________________ Fax #: _______________
Nombre *Telefono#* *Numero de Fax#*

Referring Physician's Address: __________________ City: _______________ State_________Zip: ____________
Direccion *Ciudad* *Estado* *Codigo Postal*

Preferred Pharmacy *Farmacia Preferida*

Name: ______________________________ Telephone #: ____________________
Nombre *Telefono#*

Address: ____________________________ City: _________________ State: ________ Zip Code: ______
Direccion *Ciudad* *Estado* *Codigo Postal*

Primary Insurance *Seguro Primario*

Insurance Plan Name: ____________________ ID#: ____________________ Group#: ______________
Nombre de Seguro

Claims Address: ________________________ City: ________________ State: ________ Zip: __________
Direccion

Plan Phone #: (____)_______________ Policy Holder: ☐ Self ☐ Spouse (Complete Below) ☐ Parent (Complete Below)
Telefono

Parent/Spouse Name: ____________________ Parent/Spouse Social Security #: ______________ ___DOB: ----/----/-----

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Secondary Insurance *Seguro Secundario*

Insurance Plan Name: ____________________ ID#: ____________________ Group#: ______________
Nombre de Seguro

Claims Address: ________________________ City: ________________ State: ________ Zip: __________
Direccion

Plan Phone #: (____) _______________ Policy Holder: ☐ Self ☐ Spouse (Complete Below) ☐ Parent (Complete Below)
Telefono

Parent/Spouse Name: ____________________ Parent/Spouse Social Security #: _________________DOB: ----/----/-----

Updated 1/13/2012