

*Dr. Poppy Daniels, M. D.*  
*Natural Hormone Replacement Specialist and General Gynecologist*

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**PATIENT REGISTRATION**

**PATIENT IDENTIFICATION**

Last Name			First Name		Middle	Date of Birth		Age
Street Address				City		State	Zip Code	
Home Phone		Social Security Number		<input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status		
						<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Emergency Contact		Phone Number		Relationship				

**PATIENT EMPLOYER INFORMATION**

Employer Name		Business Phone		Occupation	
Employer Address		City		State	Zip Code

**THE FOLLOWING DECLARATIONS ARE IMPORTANT—PLEASE READ CAREFULLY**

I, the undersigned, hereby agree to pay all amounts incurred by myself and other members of my family for services rendered by Poppy Daniels, M. D. Failure to make payments when requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable attorney fee, and hereby waive their rights of exemption under the laws of the State of Missouri and any other State. I understand that payment is due at the time of service, and that I am responsible for the entire bill.

I, the undersigned, have received and read Woman To Woman Gynecology's notice of privacy practices.

I, the undersigned, hereby stat that I have read and understand the above declarations.

Date: X \_\_\_\_\_ Signature of Patient, parent or guardian: X \_\_\_\_\_