Baymeadows Healthcare Patient Registration Form

Please Complete All **Date:**

Mr ☐ Mrs ☐ Miss ☐ Ms ☐	Patient Last Name	First	Middle	D.O.B

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Sex ☐ Male ☐ Female	Social Security Number	Age

Home Address	City	State	Zip Code	Home Telephone or Cell Phone

Employer/School	Occupation	Work Telephone

E-Mail Address	Driver's License No. State

Race	Ethnicity	Do you need an Interpreter Yes ☐ No ☐

Emergency Contact Name	Relationship	Phone Number

Financially Responisble (If different from patient)

Full Name	Address	State	Zip	City

INSURANCE INFORMATION

Name of Policy Holder (if Different from Patient)	Policy Holder's Date of Birth	Daytime Contact Phone No.

Address **(if different from patient)**	*Policy Holder* Social Security Number	Policy Holder's Relationship to Patient

Primary Health Insurance Co. Name	ID/Policy No.	Group No.
Secondary Health Insurance Co. Name	ID/Policy No.	Group No.

IF DUE TO WORK RELATED INJURY PLEASE FILL OUT INFORMATION BELOW

Work Related? Yes ☐ No ☐ Automobile Involved? Yes ☐ No ☐	Was Injury Reported to Supervisor? Yes ☐ No ☐	Name of Supervisor

Date of Injury / /	Address
Employer at Time of Injury	Telephone Number
Description of Injury:	Claim Number
Workers' Compensation Insurance Carrier and Address	Telephone Number

I authorize Baymeadows Healthcare to apply for benefits from my insurance company and that these benefits be made payable directly to the physician. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above billing agent Baymeadows Healthcare and am aware that any balance is my responsibility. . It is understood that any monies received from my insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. I give consent for my doctor to access my pharmacy records through my medical insurance; I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or the above carrier at any time in writing.

Patient Signature _____ Date _____