Brattleboro Memorial Hospital
EXCEPTIONAL CARE FOR OUR COMMUNITY

PATIENT REGISTRATION FORM

Please fill out both sides of this form and return it with your Photo ID and Insurance Card(s).

PERSONAL IDENTITY INFORMATION

Last Name: | **Preferred First Name:** | **Middle Initial:** | **Sex/ Gender:**

Insurance Name & Sex/Gender (if different than above):

Photo ID Name & Sex/Gender (if different than above):

Birth Certificate Name & Sex/Gender (if different than above):

Date of Birth: **Religion:**

Race: **Ethnicity:**

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other (please list):

OTHER PERSONAL STATUS INFORMATION

Do you receive Veteran's benefits? ☐ Yes ☐ No

Are you a student? ☐ Yes ☐ No

Employment Status: ☐ Unemployed ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired as of: _____ ☐ Other

EMPLOYER'S Name & Address:

EMPLOYEE Name & Address:

Is your visit accident-related? ☐ Yes ☐ No | **If yes, date of accident:** | **State where accident occurred:**

Claim #: | **Liability Insurance Name & Contact:**

Interpreter Needed? ☐ Yes ☐ No | **Workman's Compensation:**

PERSONAL CONTACT INFORMATION

Mailing Address:

Street Address (if different):

City/Town: **State:** **ZIP:**

Home Phone: **Mobile Phone:** **Other Phone:**

Email address (Required for access to BMH's Patient Portal):

Would you like online access to your medical records through BMH's Patient Portal? If "yes," an invite to the BMH Patient Portal will be emailed to you. Your ZIP code is the answer to your challenge question. ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Last Name: | **First Name:** | **Birth date:**

Home Phone | **Mobile Phone:** | **Relationship:**

Last Name: | **First Name:** | **Birth date:**

Home Phone | **Mobile Phone:** | **Relationship:**

ADVANCE DIRECTIVE

Do you have an Advance Directive?: ☐ Yes ☐ No

If "no," would you like more information and/or help in creating an Advance Directive? ☐ Yes ☐ No

MEDICAL PROVIDER INFORMATION

Primary Care Clinician Name:

Address: **Phone Number:**

Referring Clinician Name:

Address: **Phone Number:**

PRIMARY INSURANCE INFORMATION

If insurance card is available, skip this section and return it with this form. Claims are self pay until complete insurance information is provided.

Insurance Company:

Insurance Name on Card: **First:** **Last:**

Claim Mailing Address:

City: **State:** **ZIP:**

Policy #: **Group #:**

Group Name: **Subscriber's Name:**

Subscriber's DOB: **Subscriber's Employer:**

SECONDARY INSURANCE INFORMATION

If insurance card is available, skip this section and return it with this form.

Insurance Company:

Insurance Name on Card: **First:** **Last:**

Claim Mailing Address:

City: **State:** **ZIP:**

Policy #: **Group #:**

Group Name: **Subscriber's Name:**

Subscriber's DOB: **Subscriber's Employer:**

GUARANTOR INFORMATION

Complete this section if the patient is less than 18 years old..

Relationship to patient: **Last name:** **First name:**

DOB: **SSN:** **Home Phone:** **Cell Phone:**

Mailing Address (if different than patient's address):

Employment: ☐ Unemployed ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired as of: ☐ Other

Employer Name:

Please initial next to the following statements and then sign below:

_____ I do hereby declare that the above information is true to the best of my knowledge.

_____ I have received notice of BMH Medical Group Privacy Practices, and I understand how the BMH Medical Group can use and disclose protected health information about me.

_____ I do hereby consent to and authorize the performance of all treatments and medical services by the staff of BMH Medical Group and its team which they deem advisable and have discussed with myself and/or my agent.

_____ I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage.

_____ I hereby Authorize BMH Medical Group to release information requested by the insurance company and/or its representative.

Signature: **Date:**

Name (print): **Relationship to patient:**