BMH MEDICAL GROUP
a Department of Brattleboro Memorial Hospital

PATIENT REGISTRATION FORM

PATIENT INFORMATION

*Last Name: _____ *First Name: _____ Middle Initial:_____ Maiden:_____

*DOB_____ *Sex: _____ * Race: _____Marital Status: _____

Primary Care Provider _____Referring Provider (if not primary care doctor) _____

Primary Language_____Religion_____ Ethnicity: _____

Preferred Pharmacy: _____ Location: _____

ADDRESS

*Mailing Address: _____

Street Address (if different):_____

*City: _____ *State: _____ * Zip Code:_____

PHONE

*Home: _____ Work: _____ Cell: _____ *Primary _____

E-mail:_____*Preferred Method of Contact_____

May we leave message with patient information on the message machine? _____ _____

*Where did you hear about us? (Circle**)** **Friend/Family** **PCP/Other MD** **Newspaper** **BMH Website**

BMH Newsletter **White Pages** **Yellow Pages** **Other:** _____

EMPLOYER INFORMATION

Company Name: _____ _____Occupation: _____

Address: _____

City_____State_____Zip:_____

Phone: _____

GUARANTOR/ CONTACT INFORMATION

Guarantor Name: _____ DOB: _____

Phone: _____ Relationship to Patient: _____

*Emergency Contact: _____ DOB: _____

*Phone: _____ *Relationship to Patient: _____

***Mandatory Fields (please complete the asterisked fields)**

INSURANCE INFORMATION

***Primary Insurance**: _____

*Primary Insured Party Name: _____ *DOB: _____

*Relationship to Patient: _____*Policy #:_____Group#:_____

Effective Date: _____ Expiration Date:_____

Secondary Insurance: _____

Primary Insured Party Name: _____ DOB:_____

Relationship to Patient: _____Policy #:_____Group#_____

* Is this Worker's Comp/Motor Vehicle Accident or Other Liability Claim? _____If Yes, Date of Injury_____

Claim #_____Contact Name/Case Worker: _____

Liability Insurance Name:_____Phone #_____

Address_____

_____

*_____The above information is true to the best of my knowledge, please initial.

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. 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 PT:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Brattleboro Memorial Hospital, BMH Medical Group, and the Community Health Team Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we will provide you, copies of the current notice are available by accessing our website at bmhvt.org.

*Signature of Patient or Patient's Representative:_____

*Name (PRINT):_____*DATE:_____

Relationship to the Patient:_____

***Mandatory Fields (please complete the asterisked fields)**