|  |  |
| --- | --- |
|  | **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: |  | **First Name:** |  | **Middle Initial:** |  | **Gender:** |  |
| **Insurance Name & Gender (if different than above):** |
| **Photo ID Name & Gender (if different than above):** |
| **Birth Certificate Name & Gender (if different than above):** |
| D.O.B.: |  | 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 benefits?** | 🞎 Yes 🞎 No |  |  |
| **Are you a student?** | 🞎 Yes 🞎 No | **If “yes”, where?** |
| Employment Status: | 🞎 Unemployed 🞎 Part-Time 🞎 Full-Time 🞎 Self-Employed 🞎 Retired 🞎Other |
| **Is your visit accident related?** | 🞎 Yes 🞎 No |  | **Date of accident** |  | **In what state did it occur?** |  |
| **Employer Name and Address:** |  |  |
| **Claim #:** | **Liability Insurance Name and Contact:**  |
| **Interpreter Needed?** 🞎 Yes 🞎 No |
|  |
| Personal Contact Information |
| Mailing Address: |
| Street Address (if different): |
| Town:  |  | State: |  | Zip: |  |
| Home Phone:  |  | Mobile Phone: |  | Other Phone: |  |
| Email address:  |
| Would you like online access to your medical records on the BMH Patient Portal? If “yes” an invite to the BMH Patient Portal will be sent to your email. Your answer to the challenge question will be your zip code. | 🞎 Yes 🞎 No |
|  |  |
| Emergency Contact Information |
| **Last Name:**  | **First Name:** | **DOB:** |
| **Home Phone:**  | **Mobile Phone:** | **Relationship:** |
| **Last Name:**  | **First Name:** | **DOB:** |
| **Home Phone:**  | **Mobile Phone:** | **Relationship:** |
|  |  |  |  |  |  |
| ADVANCE DIRECTIVE |
| **Do you have an Advance Directive?** | 🞎 Yes 🞎 No | **If “no”, would you like more information or assistance to create one?** | 🞎 Yes 🞎 No |
| MEDICAL PROVIDER INFORMATION |
| Primary Care Clinician Name:  |
| Address:  | Phone Number: |
| Referring Clinician Name:  |
| Address:  | Phone Number: |
|  |  |
| PRIMARY INSURANCE INFORMATIONIf insurance card is available, return it with this form and skip this section. Claims are self-pay until complete insurance information is provided. |
| **Insurance Company:** |
| **Insured 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 INFORMATIONIf insurance card is available, return it with this form and skip this section. |
| **Insurance Company:** |
| **Insured 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 InformationComplete this section if the patient is less than 18 years old. |
| **Relationship to patient:**  |  | **Last name:** |  | **First Name:** |  |
| **DOB:**  |  | **SSN:** |  | **Home Phone:** |  | **Mobile Phone:** |  |
| **Mailing Address (if different than patient’s address):** |
| **Employment**: 🞎 Unemployed 🞎 Part-Time 🞎 Full-Time 🞎 Self-Employed 🞎 Retired 🞎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:** |