

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

Patient Registration Form

PLEASE PRINT CLEARLY

Date _____

Account Number _____

PATIENT INFORMATION				
Patient's Last Name:	First Name:	Middle Initial:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient's Address: Street Info				Apt. #:
City:	State, ZIP:	Patient's Home Phone #:	Patient's Cell Phone #:	
Billing Street address of Responsible party - If different from above:		Race (Optional): <input type="checkbox"/> Black or African-American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other		
City:	State, ZIP:	Social Security #:	Email:	
Employer's Name:		Work Phone #:		
Pharmacy Name, Address, and Telephone #:				
Referring Physician's Name and Telephone #:			Primary Care Physician's Name and Telephone # (if different from referring)	

INSURANCE INFORMATION		
Primary Insurance Company Name:		
Identification or Policy Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
Policyholder's Date of Birth:	Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Effective Dates of Insurance:
Secondary Insurance Company Name:		
Identification Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
Policyholder's Date of Birth:	Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Effective Dates of Insurance:

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT		
Name:	Relationship To Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Child <input type="checkbox"/> Other	
Home Phone #:	Work Phone #:	Cell Phone #:

AUTHORIZATION AND RELEASE

- * I authorize any holder of medical information about me to release this information to the Health Care Financing Administration, my insurance company or its intermediaries or carriers, or to this physician's office.
- * I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicare supplemental carrier, private insurance, and any other health plan to Bryn Mawr Medical Specialists Association. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.
- * I understand that I am financially responsible for all charges whether or not paid by said insurance.

SIGNATURE _____ DATE _____

Please hand this form and your insurance cards to the Receptionist.