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: ❑ Male ❑ Female
Patient's Street Address:				Marital Status: ❑ S ❑ M ❑ D ❑ W
City:	State, ZIP:		Patient's Home Phone #:	Patient's Cell Phone #:
Billing Street Address of Responsible Party (if different from above):			Race: ❑ African-American ❑ Asian ❑ Caucasian ❑ Other Ethnicity: ❑ Hispanic ❑ Non-Hispanic	
City:	State, ZIP:		Primary Language: ❑ English ❑ Other:_____	Email:
Employer's Name:			Work Phone #:	
Pharmacy Name, Address, and Telephone #:				
Referring Physician's Name and Telephone #:			Primary Care Physician's Name and Telephone #:	

INSURANCE INFORMATION		
Primary Insurance Company Name:		
Identification or Policy Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Partner ❑ Dependent ❑ Other	
Policyholder's Date of Birth:	Policyholder's Sex: ❑ Male ❑ Female	Effective Dates of Insurance:
Secondary Insurance Company Name:		
Identification Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Partner ❑ Dependent ❑ Other	
Policyholder's Date of Birth:	Policyholder's Sex: ❑ Male ❑ Female	Effective Dates of Insurance:

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT		
Name:	Relationship To Patient: ❑ Spouse ❑ Partner ❑ Parent/Guardian ❑ Child ❑ 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.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

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

REV 6/16