

# 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 (M) <input type="checkbox"/> Female (F) Gender Identity: <input type="checkbox"/> Transgender Male (FTM) <input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Genderqueer (G) <input type="checkbox"/> Other (O)
Patient's Street Address:			Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
City:	State, ZIP: <small>(9 digit if known)</small>	Patient's Home Phone #:	Patient's Cell Phone #:	
<u>Billing</u> Street Address of Responsible Party (if different from above):			Race: <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Other Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
City:	State, ZIP:	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> 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		
<b>Primary Insurance Company Name:</b>		
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"/> Partner <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:
<b>Secondary Insurance Company Name:</b>		
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"/> Partner <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"/> Partner <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Child <input type="checkbox"/> Other	
Home Phone #:	Cell Phone #:	Work Phone #:

### AUTHORIZATION AND RELEASE

- \* I authorize any holder of medical information about me to release this information to the Centers for Medicare and Medicaid Services, 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 ("BMMSA"). I further agree to allow BMMSA to file an appeal on my behalf with my health plan. 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.**