

**BAPTIST PHYSICIAN NETWORK  
PATIENT REGISTRATION**

Patient Name \_\_\_\_\_  
                                Last  First  Initial  
Address \_\_\_\_\_                                City\_\_\_\_\_                                State\_\_\_\_\_                                Zip\_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone# \_\_\_\_\_ Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Preferred Language \_\_\_\_\_ Marital Status \_\_\_S\_\_\_M\_\_\_D\_\_\_W

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Email Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

Pharmacy: \_\_\_\_\_

**PRIMARY INSURANCE**

Insured Name \_\_\_\_\_ Birth Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
                                Last  First  Initial

Relation to Insured: \_\_\_Self\_\_\_Spouse\_\_\_Other                                  Primary Care Physician \_\_\_\_\_

Insurance \_\_\_\_\_ Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

**SECONDARY INSURANCE**

Insured Name \_\_\_\_\_ Birth Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
                                Last  First  Initial

Relation to Insured: \_\_\_Self\_\_\_Spouse\_\_\_Other                                  Primary Care Physician \_\_\_\_\_

Insurance \_\_\_\_\_ Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

**RESPONSIBLE PARTY**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relation to Patient \_\_\_Self\_\_\_Spouse\_\_\_Other                                  Phone # \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

I hereby authorize payment of Medicare, ALL other insurance benefits to be made directly to Baptist Physician Network for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize to release all information necessary to secure the payment of benefits.

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient (or parent if Minor)