

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)