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)