

SSN: _____ Phone: _____ Relationship to Patient:

Emergency Contact: _____ DOB:

Phone: _____ Relationship to Patient: _____

Other Contact Name: _____ DOB:

Phone: _____ Relationship to Patient: _____

INSURANCE INFORMATION

If this visit is due to a job related injury or automobile accident please let the receptionist know

Primary Insurance: _____

Primary Insured Party Name: _____ DOB: _____

SSN: _____ Phone: _____ Relationship to Patient: _____

Policy Number: _____ Group Number _____

Effective Date: _____ Expiration Date: _____

Secondary Insurance:

Primary Insured Party Name: _____ DOB: _____

SSN: _____ Phone: _____ Relationship to Patient: _____

Policy Number: _____ Group Number _____

Effective Date: _____ Expiration Date: _____

The above information is true to the best of my knowledge and I authorize the release of any medical information necessary to determine my benefits and to process any claim for service provided.

Signature: _____

Date: _____

I authorize my insurance benefits to be paid directly to my physician. I understand that I am financially responsible for any balance.

Signature: _____

Date: _____

I acknowledge that I have been made aware of the BMH Physician Group Notice of Privacy Practices. I am aware that a copy of the privacy practices is located in the waiting room and will be made available individual upon request.

Signature of Patient or Patient's Representative

Date

Description of Representative's Authority