

REGISTRATION FORM

| |
|-----------|
| Acct #: |
| Provider: |

Patient Information

| | | | | |
|--|-----------------|---|--|---------------------------------|
| Social Security # | Full Name: Last | First | Middle | Maiden (Other) |
| Address: Street or Rural Route | | City | State | Zip Code |
| Home Phone # | Work Phone # | Extension | Cell Phone # | |
| Date of Birth | Age | Marital Status Single Married Widowed Divorced | | Sex (circle one) Female Male |
| Reason for Visit | | | Patient's Primary Care Physician and Phone # | |
| Patient Additional Information: | | | | |
| Can messages be left on voicemail? Home: Y / N Work: Y / N Cell: Y / N | | | Emergency contact for patient: | |
| Information can be released to the following person(s) (include date of birth) | | | Name: | |
| | | | Phone: Relationship: | |
| Patient's email address: | | | Living Will: Y / N Power of Attorney Y / N | |

PATIENT CURRENT EMPLOYMENT INFORMATION

| | | |
|----------------------------|---|------------------|
| Occupation | Employer | Employer Address |
| If Student Indicate School | If Patient is a Minor, provide Name of Parent(s)) or Legal Guardian (legal documentation required): | |

RESPONSIBLE PARTY Please check box if Responsible Party is the same as the Patient.

| | | | | |
|---|-----------------|---------------------------------|------------------------------------|----------------|
| Social Security # | Full Name: Last | First | Middle | Maiden (Other) |
| Address: Street or Rural Route P.O. Box | | City | State | Zip |
| Home Phone # | Work Phone # | Extension | Email Address | |
| Date of Birth | Age | Sex (circle one) Female Male | Relationship to Patient | |
| Responsible Party Employer | | | Responsible Party Employer Address | |

INSURANCE INFORMATION Please provide copy of your insurance card to front office representative.

| | | | |
|--|-------------------------|---|-------------------------|
| Name of Primary Insurance Company | | Name of Secondary Insurance Company | |
| Subscriber (Policyholder if not patient) | Date of Birth | Subscriber (Policyholder, if not patient) | Date of Birth |
| Subscriber Address, City, State, & Zip | | Subscriber Address, City, State, & Zip | |
| Social Security # | Relationship to Patient | Social Security # | Relationship to Patient |

| | | | |
|--|------|--------------------------|-----|
| Is this visit due to an accident? Y N | | Date of Accident/On-set: | |
| If yes, is the accident an (circle one) Auto Accident Work Injury Other | | | |
| Explain other: | | | |
| Employer Name | | Phone # () | |
| Mailing Address | City | State | Zip |
| Work Company Carrier Name | | | |
| Is this visit for a pre-employment exam? Y N | | If yes, please complete | |
| Potential Employer Name | | Phone # () | |
| Mailing Address | City | State | Zip |

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice.

Signature of Patient, Parent or Legal Guardian _____ Date _____

If patient is a minor:
 My signature authorizes evaluation and treatment for my child and also authorizes consent to medical and surgical procedures and immunizations for the child named herein _____ (Name of Child).

Financial Responsibility / Medical Information Release

I hereby authorize payment of medical benefits directly to BroMenn Physicians Management Corporation, DBA BroMenn Medical Group and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim and/or for the purpose of determining eligibility of employment. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV"), Drug Screen and Breath Alcohol Testing. **I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies and/or employer. I agree that all amounts are due upon request and are payable to BroMenn Medical Group. I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of BroMenn Medical Group, if any.**

Signature of Patient, Parent or Legal Guardian _____ Date _____

| | |
|--|----------|
| FOR OFFICE USE ONLY: | |
| Copy of insurance card obtained and scanned | _____ |
| | Initials |
| Current insurance verified and already on file | _____ |
| | Initials |
| Patient's demographics verified and updated | _____ |
| | Initials |
| Photo ID verified for new patients and/or per practice specific policy | _____ |
| | Initials |