BETHANY MEDICAL CENTER REGISTRATION FORM

Chart #:

If you are under 18 years old, or someone else is responsible for your bill please list all their informaiton under Guarantor section.

Patient Information: Last / First / Middle Initial	Guarantor Information:
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Cell:	Home Phone: Cell:
Email:	Email:
Social Security #: Race:	Social Security #: Race:
Marital Status: S M W D D.O.B Age:	Marital Status: S M W D D.O.B Age:
Employed: FULLTIME / PARTIME / STUDENT / RETIRED	Employed: FULLTIME / PARTIME / STUDENT / RETIRED
Employer Name:	Employer Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Work Phone #:	Work Phone #:
Primary Insurance Information:	**Secondary Insurance Information:**
Insurance Name:	Insurance Name:
Group #:	Group #:
Policy #:	Policy #:
Copay: $ or Deductible: $	Copay: $ or Deductible: $
Policy Holder's Name:	Policy Holder's Name:
Relation to you:	Relation to you:
Birthday:	Birthday:
Social Security #:	Social Security #:
Employer: Work Phone #:	Employer: Work Phone #:
Emergency Contacts	**Additional Information**

Emergency Contacts

Name: ____________ Relation: ____________
Work Phone #: ____________ Home Phone #: ____________

Name: ____________ Relation: ____________
Work Phone #: ____________ Home Phone #: ____________

Do you have a Primary Care Doctor? Yes / No
If yes, name of Doctor: ____________

Would you like to receive more information about Bethany Medical Center? Yes / No

Additional Information

Was this an accident? Yes / No
If yes: (please circle one): Job Related / Home / Other
Description: ____________

Your preferred pharmacy:

How did you hear about our practice? (please circle one)
TV / Radio / Ad / Drive-By / Friend-Family / Employer / Physician
If referred by a Physician, please print name of Physician:

This medical practice works with its patients to minimize difficulty in the payment of fees for services. Upon arrival to your appointment, you'll be asked to pay those unmet deductible amounts & co-insurance amounts that your insurance company authorizes to be collected. Further, we automatically file insurance claims with your insurance company; therefore, please insure that all insurance information listed above is correct.* With some procedures, outpatient benefits may apply. I understand I may be billed accordingly. **I understand that I'm responsible for any amount not covered by my insurance company.**

Authorization to Release Medical Information: The undersigned does hereby authorize my Provider to release any information pertaining to my medical treatment to any insurance company or companies & Physician or health care Provider to whom I might be referred for medical reasons.

Consent to Treat: I hereby authorize medical treatment of myself\my minor by the Providers of Bethany Medical Center. I am aware that the practice of medicine is not an exact science & acknowledge that no guarantees have been made concerning by care.

I hereby assign all medical and\or surgical benefits, to include major medical benefits to which I'm entitled, including Medicaid, Private insurance and other health plans to: ***Bethany Medical Center.***

____________ Date: ____________

Patient Signature and/or Responsible Party (ie:POA or Guarantor)

Front Office Person initials: ____________