BMG | BAPTIST MEDICAL GROUP

PATIENT REGISTRATION

MRN_____

Date_____ Referring Physician _____ Primary Care Physician _____

Patient Last Name_____ First Name _____ Middle Initial_____ Suffix _____(Jr/Sr/II etc.)

Address _____ City_____ State_____Zip _____ County _____

Patient's Nickname _____ ☐ Male ☐ Female Date of Birth _____/_____/_____

Home phone _____ Work phone _____ext._____ Cell phone _____

Soc. Sec. # _____ If patient is a student over 19, is he/she: ☐ Full-time ☐ Part-time

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouse: _____

Patient E-mail Address _____

Patient Pharmacy _____ Pharmacy Phone _____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Race: ☐ Ame. Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Not Hispanic ☐ Other_____

Ethnic Background: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Other_____

Employer: _____ Employer Address _____

Is this visit due to an accident? ☐ Y ☐ N If yes, explain: _____ Is this visit job related? ☐ Y ☐ N

Date of injury: _____/_____/_____ Supervisor name: _____ Phone: _____

Emergency Contact

Name_____ Relationship _____Phone _____

Responsible Party Information

Relationship to patient _____ Date of birth: _____/_____/_____

Name_____ Home phone _____Cell phone_____

Address _____ City_____ State _____Zip _____

Employer _____ Work Phone_____

Employer Address _____ City_____ State _____Zip _____

Emergency Contact Other Than Responsible Party

Name _____ Relationship _____ Home phone _____ Cell Phone _____

Primary Insurance

Insurance Co. _____

Group # _____Policy # _____

Subscriber _____ Date of Birth: ____/____/____

Relationship to Patient: _____

Secondary Insurance

Insurance Co. _____

Group # _____Policy # _____

Subscriber _____ Date of Birth: ____/____/____

Relationship to Patient: _____

_____

Signature of patient or person authorized to sign for patient

Date_____