

PATIENT REGISTRATION FORM

Name: _____
Last First Middle

Home Address: _____
Street City State Zip

Gender: Female Male **Phone #:** _____
 Home Cell Work
****Please check the phone number for receiving confirmation calls****

Date of Birth: _____

Primary Language: _____ **Ethnicity:** _____

Race: American Indian Asian Black Caucasian Eskimo Hispanic
 Pacific Islander Other

Employed By: _____ **Occupation:** _____

Person to contact in case of emergency: _____
Name Phone Relationship

How did you hear about Bayspring: _____

1) Primary Insurance Company Name: _____

Effective Date: _____ ID Number: _____

Plan Group Number: _____

Amount of Copayment: _____ Type of Coverage: HMO PPO POS

Primary Care Physician: _____ Medical Group: _____

Insurance Address for Claims: _____
Street City State Zip

Name of Insured: _____ Relationship to Insured: _____

Subscriber Date of Birth: _____

2) Secondary Insurance Company Name: _____

Effective Date: _____ ID Number: _____

Plan Group Number: _____

Amount of Copayment: _____ Type of Coverage: HMO PPO POS

Primary Care Physician: _____ Medical Group: _____

Insurance Address for Claims: _____
Street City State Zip

Name of Insured: _____ Relationship to Insured: _____

Subscriber Date of Birth: _____

Assignment of Benefits: I, the undersigned, have insurance coverage with the above named carrier and assign directly to Bayspring Medical Group all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that if this or any other visit precedes the effective date of my enrollment in my insurance company, I will be held responsible for any and all fees incurred. I hereby authorize Bayspring Medical group to release all information necessary to secure the payments of benefits.

Signature: _____ Date: _____