

BOYERTOWN MEDICAL ASSOCIATES
23 N. WALNUT STREET - BOYERTOWN, PA 19512
(610) 367-2259

PATIENT REGISTRATION

Patient Name _____

Patient Address _____

City _____ State _____ Zip Code _____ Patient Telephone _____

Patient Birthdate ____/____/____ Sex: M ___ F ___ Patient Social Security Number _____

Patient Status: Single ___ Married ___ Other ___ Employed ___ Full-time Student ___ Part-time Student ___

Employer/School Name _____

Employer/School Address _____

City _____ State _____ Zip Code _____

Condition Related To: Employment Yes ___ No ___ Auto Accident Yes ___ No ___ Other Accident Yes ___ No ___

Emergency Telephone _____ Emergency Party _____

Send Bills To _____

Billing Address _____

City _____ State _____ Zip Code _____

Referring Physician: _____

Primary Insurance _____

Policy/Agreement/ID Number _____ Group Number _____

Insured Name _____

Insured Address _____

City _____ State _____ Zip Code _____ Insured Telephone _____

Insured Birthdate ____/____/____ Sex: M ___ F ___ Insured Social Security Number _____

Insured Employer Name _____

Insured Employer Address _____

City _____ State _____ Zip Code _____

Relationship: Self ___ Spouse ___ Child ___ Other ___

Secondary Insurance _____

Policy/Agreement/ID Number _____ Group Number _____

Insured Name _____

Insured Address _____

City _____ State _____ Zip Code _____ Insured Telephone _____

Insured Birthdate ____/____/____ Sex: M ___ F ___ Insured Social Security Number _____

Insured Employer Name _____

Insured Employer Address _____

City _____ State _____ Zip Code _____

Relationship: Self ___ Spouse ___ Child ___ Other ___

Other Insurance _____

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plan to Pottstown Medical Specialists, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient or Authorized Person _____ Date ____/____/____