



PATIENT DEMOGRAPHIC AND REGISTRATION FORM

TODAY'S DATE: ____ / ____ / ____

PATIENT NAME (LAST, FIRST): _____

PATIENT ADDRESS: _____ DATE OF BIRTH: ____ / ____ / ____

_____ GENDER: _____

PATIENT'S PHONE: _____ PATIENT / GUARDIAN EMAIL: _____

RESPONSIBLE PARTY/GUARDIAN: _____ RELATIONSHIP: _____

MAILING ADDRESS: _____ HOME PHONE: _____

_____ CELL PHONE: _____

WORK PHONE: _____

PARENT/GUARANTOR #1: _____ PHONE: _____

ADDRESS: _____ EMAIL: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

PARENT/GUARANTOR #2: _____ PHONE: _____

ADDRESS: _____ EMAIL: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

PRIMARY INSURANCE: _____ ID #: _____

INS. ADDRESS: _____ CARDHOLDER: _____

_____ CARDHOLDER DOB: _____ SEX: _____

INS. TELEPHONE #: _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE: _____ ID #: _____

INS. ADDRESS: _____ CARDHOLDER: _____

_____ CARDHOLDER DOB: _____ SEX: _____

INS. TELEPHONE #: _____ EFFECTIVE DATE: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize BCHP to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered. I have been advised that if my insurance requires a co-pay, it is due at the time of the visit.

Signature of Patient/ Guardian: _____

Date: _____