Patient Registration Form – BMC

Patient Information

Patient Last Name	First Name	Middle Name	Alias Name

Address (Street or Box)	City	State Zip

Home Phone:	Work Phone:	Mobile Phone :

E-mail (Allows us to send you important messages.)	How and Where Did You Learn About This Hospital:

Social Security Number:	Marital Status:
	☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Driver's License #:	Condition/Illness Related to:
	☐Illness ☐Employment ☐Auto ☐Other

Relation to Insurance Policy Holder:	Gender:	Date of Birth:	Do You Have Any Medical Directives:
☐Self ☐Spouse ☐Child ☐Other	☐Male ☐ Female		☐Yes ☐ No

Race:	Ethnicity:
☐American Indian/Eskimo/Aleut ☐Asian ☐Pacific Islander ☐Black ☐White ☐Other _____	☐Hispanic/Latino Origin ☐Non-Hispanic/Latino Origin

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date

Claims Mailing Address (Street or Box)	Claims Mailing Address (Street or Box)

City	State	Zip	City	State	Zip

Policy ID Number	Group ID Number	Policy ID Number	Group ID Number

Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth

Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient

Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #

Subscriber Employer Address (Street or Box)	Subscriber Employer Address (Street or Box)

City	State	Zip	City	State	Zip

Additional Medical Information

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐Yes ☐No Your Initials:_____

If you answered yes, please fill out the accident specific form, available at the front desk.

Are you pregnant:	Do you have a pacemaker:	Family Physician:
☐Yes ☐ No	☐ Yes ☐No	

Emergency Contact Information:

Person's Name_____ Relationship to Person_____

Phone Number _____

AFFIX PATIENT INFO LABEL HERE
Date of Service will be present on patient sticker