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.)

☐ Male ☐ Female Date of Birth ______/______/______ Soc. Sec. #_______________________________

Physical Address _________________________City ____________________ State______ Zip ___________ County _______________

Mailing Address __________________________City ____________________ State______ Zip ___________ County _______________

Home phone ______________________ Work phone _________________________ext._______ Cell phone ______________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Patient E-mail Address___________________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other ____________________________ Need Interpreter? ☐ Yes ☐ No

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

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

Employer: ___________________________________ Employer Address ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

Job Title: ____

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

Name_______________________________________ Home phone _______________________Cell phone _______________________

Relationship to patient ________________ ☐ Male ☐ Female Date of birth: ______/______/______ Soc. Sec. #___________________

Address ____________________________________ City ___________________________ State ___________Zip _________________

Employer ____ Employer Address ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

Primary Insurance

Insurance Co. ____

Group # _________________Policy # ______________________

Subscriber ____

Relationship to Patient: __________________ Date of Birth: ____/____/____

☐ Male ☐ Female Soc. Sec. # __________ Phone __________

Employer ____

Address ____

____

Signature of patient or person authorized to sign for patient

Secondary Insurance

Insurance Co. ____

Group # _________________Policy # ______________________

Subscriber ____

Relationship to Patient: __________________ Date of Birth: ____/____/____

☐ Male ☐ Female Soc. Sec. # __________ Phone __________

Employer ____

Address ____

Date_________________________

Form #21-102.2 (07/18)