BMG | BAPTIST MEDICAL GROUP

PATIENT REGISTRATION

Patient Last Name	Date	Referring Physician	Primar	y Care Physician _	
Physical Address	Patient Last Name	First Name		Middle Initial	Suffix(Jr/Sr/II etc.
Mailing Address	☐ Male ☐ Female	Date of Birth/ Soc.	Sec. #		<u> </u>
Home phone	Physical Address	City	State	_ Zip	County
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 ob related? Y 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: /	Mailing Address	City	State	_ Zip	County
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 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: /	Home phone	Work phone	ext	Cell phone	
Ethnic Background:	Marital Status: Ma	rried Single Widowed Divorced	Patient E-mail Addre	ess	
Race: Ame. Indian/Alaska Native	Preferred Language:	☐ English ☐ Spanish ☐ Other		Need Interpr	eter? ☐ Yes ☐ No
Employer:	Ethnic Background:	☐ Hispanic/Latino ☐ Not Hispanic/Not Lati	no 🗆 Other		
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 Date of Injury: /	Race:	ı/Alaska Native □ Asian □ Black/African	American White/Not I	Hispanic ☐ Othe	r
Job Title:	Employer:	Employer A	ddress		
Is this visit due to an accident?	Employment Status:	☐ Full Time ☐ Part Time ☐ Not Employed	☐ Retired ☐ Active	Duty Military 🗌 Di	sabled
Date of injury:/ Supervisor name:Phone:					
Responsible Party Information Name					
Responsible Party Information Name		// Supervisor name:		Phone:	
Responsible Party Information Name					
Name	Name	Relationship		Phone	
Relationship to patient Male Female Date of birth:/ Soc. Sec. #					
Address	Name	Home phon	e	Cell phone_	
Employer Employer Address Employer Address Employment Status:	Relationship to patient	t	ate of birth:/	/ Soc. Se	ec. #
Employment Status: Full Time Part Time Not Employed Retired Active Duty Military Disabled Student FT/PT Primary Insurance Secondary Insurance Insurance Co. Insurance Co. Group # Policy # Policy # Policy # Subscriber Subscriber Relationship to Patient: Date of Birth: Relationship to Patient: Date of Birth: Male Female Soc. Sec. # Phone Male Female Soc. Sec. # Phone Employer Employer	Address	City		State	Zip
Primary Insurance Insurance Co	Employer	E	mployer Address		
Insurance Co.	Employment Status:	☐ Full Time ☐ Part Time ☐ Not Employed	☐ Retired ☐ Active	Duty Military 🗌 Di	sabled
Group #Policy #	Primary Insurance		Secondary Insurance	9	
Subscriber	Insurance Co.		Insurance Co.		
Relationship to Patient: Date of Birth:// Relationship to Patient: Date of Birth:// Male	Group #Policy #		Group #Policy #		
□ Male □ Female Soc. Sec. # □ Phone □ Male □ Female Soc. Sec. # □ Phone Employer Employer	Subscriber		Subscriber		
Employer Employer	Relationship to Patient: Date of Birth:/		Relationship to Patient: Date of Birth://		
	☐ Male ☐ Female Soc. Sec. # Phone		☐ Male ☐ Female Soc. Sec. # Phone		
Address Address	Employer		Employer		
	Address		Address		
Date Signature of patient or person authorized to sign for patient			Date		