

**BACKUS PHYSICIAN SERVICES
REGISTRATION INFORMATION FORM**

Physician: _____
Reason for Visit: _____

PATIENT NAME: _____ **SSN:** _____

ADDRESS: _____
Street City/State Zip

HOME PHONE: _____ **CELL PHONE:** _____

DOB: _____ **Sex:** M F **Marital Status:** S M D W

EMPLOYER: _____ **WORK PHONE #** _____

.....
PRIMARY CARE PHYSICIAN: _____
Name Phone #

PHARMACY: _____
Name Location Phone #

.....
PERSON RESPONSIBLE FOR BILL: *Are you here today for an injury for which another party might be responsible? If yes please let receptionist know.*

Guarantor Name: _____

Address: _____
Street City & State Zip

Home Phone # _____ **Cell Phone #** _____ **Work Phone #** _____

SSN: _____ **Relationship to Patient:** _____

.....
HEALTH INSURANCE INFORMATION: *Please provide office with current copy of insurance card(s).*

PRIMARY INS: _____ **POLICY HOLDER:** _____

ID # _____ **POLICY HOLDER SSN:** _____

GROUP #: _____ **POLICY HOLDER DOB:** _____

SECONDARY INS: _____ **POLICY HOLDER:** _____

ID # _____ **POLICY HOLDER SSN:** _____

GROUP #: _____ **POLICY HOLDER DOB:** _____

PLEASE TURN OVER FOR SIGNATURE

PATIENT CONSENT AND AUTHORIZATION

I hereby authorize BPS personnel and contracted staff to perform any and all tests or procedures relative to my care, injury/illness and/or physical examination as deemed necessary and advisable by the provider and/or employer.

I hereby authorize the release of medical information pertaining to any occupational healthcare, provided to me at this facility, to my employer, insurance company and medical provider involved in the diagnosis.

I hereby give permission to my third party payer (employer, insurance carrier, PPO, HMO) to directly pay BPS for services rendered to me. I understand that I am responsible for any applicable balance remaining after my insurance has paid and I am to pay the difference within 30 days of notification by BPS or my insurance carrier.

I have been made aware that if the physician does not participate with my health insurance plan I will be responsible for any applicable charges.

I understand and accept that I must pay for any charges which I am billed by BPS. This may include any claims denied by my third party payer, including any claims denied by employer's workers' compensation insurance carrier. I understand that if these medical bills are not paid on time, they may be turned over to a collection Agency. If this happens, I understand that I will have to pay, and I agree to pay reasonable collection and attorney fees in addition to lawful interest and cost.

My signature below indicates that I have read and understand each of the paragraphs above.

DATE: _____ SIGNATURE: _____ WITNESS: _____
REASON FOR VISIT: _____

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