Bridgewater Primary Care and Cardiology, LLC **Patient Registration**

Name of Patient: _____
Last *Suffix* *First* *Middle Initial*

Social Security #: _____ Home Tel.: ( ) _____

Address: _____ Cell Phone: ( ) _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Tel.: ( ) _____

Your Date of Birth: _____ Sex: o M o F Marital Status: _____

Email: _____

Home address, if different from above: _____

City: _____ State: _____ Zip: _____ Tel.: ( ) _____

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Business Tel.: ( ) _____ Pharmacy Tel.: ( ) _____

Pharmacy Address**:**

INSURANCE INFORMATION

OFFICE WILL PHOTOCOPY INSURANCE CARD PLEASE GIVE ADDITIONAL INFORMATION BELOW

1. PRIMARY INSURANCE	**2. SECONDARY INSURANCE**
Relationship to Subscriber: (Check one) ❑ Self ❑ Spouse ❑ Child ❑ Other:	Relationship to Subscriber: (Check one) ❑ Self ❑ Spouse ❑ Child ❑ Other:
Subscriber Name if different from self:	Subscriber Name if different from self:
Subscriber Date of Birth:	Subscriber Date of Birth:

Name of Primary Care Physician: _____ Tel.: ( ) _____

Medical Information and Payment Authorization

I request that payment of authorized medical benefits be made on my behalf to Bridgewater Primary Care and Cardiology, LLC (BPCAC). For services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any other insurer, any information needed to determine these benefits payable for related services. A copy or system generated printout of this release will be as valid as the original form.

Although I have indicated that I am covered by the above health insures(s), I acknowledge and agree that I am personally responsible for any co-payments and/or deductibles associated with the services I receive which are not covered by my insurance and that I will be personally liable for all charges associated with the services I receive. If for any reason it is determined that my insurance is not obligated to pay for said services or that I am in fact not covered by the insurance identified above.

Initial: _____

Authorization to Download Pharmacy Benefit Information

I request that pharmacy benefit information be made available to Bridgewater Primary Care and Cardiology, LLC from RxHub. This information will be imported into the electronic medical record for Prescription Medication History accuracy.

Initial: _____

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____