PMSI
COMPREHENSIVE HEALTHCARE
For Life

BOYERTOWN MEDICAL ASSOCIATES
23 N. WALNUT STREET - BOYERTOWN, PA 19512
(610) 367-2259

PATIENT REGISTRATION

Patient Name _____
Patient Address _____
City _____State _____Zip Code _____Patient Telephone _____
Patient Birthdate ____/____/____ Sex: M ___ F ___ Patient Social Security Number _____
Patient Status: Single ___ Married ___ Other ____ Employed ____ Full-time Student ____ Part-time Student ____
Employer/School Name _____
Employer/School Address _____
City _____State _____Zip Code _____
Condition Related To:Employment Yes ___No ___ Auto Accident Yes ___No ___ Other Accident Yes ___No ___
Emergency Telephone _____ Emergency Party _____
Send Bills To _____
Billing Address _____
City _____State _____Zip Code _____
Referring Physician: _____

Primary Insurance _____
Policy/Agreement/ID Number _____Group Number _____
Insured Name _____
Insured Address _____
City _____State _____Zip Code _____Insured Telephone _____
Insured Birthdate ____/____/____ Sex: M ___F___ Insured Social Security Number _____
Insured Employer Name _____
Insured Employer Address _____
City _____State _____Zip Code _____
Relationship: Self ___ Spouse ___Child ___ Other ___

Secondary Insurance _____
Policy/Agreement/ID Number _____Group Number _____
Insured Name _____
Insured Address _____
City _____State _____Zip Code _____Insured Telephone _____
Insured Birthdate ____/____/____ Sex: M ___F___ Insured Social Security Number _____
Insured Employer Name _____
Insured Employer Address _____
City _____State _____Zip Code
Relationship: Self ____Spouse ____Child ____Other ____

Other Insurance _____
_____

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plan to Pottstown Medical Specialists, Inc.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient or Authorized Person _____Date _____/_____/_____