

**BROOKSIDE FAMILY PRACTICE & PEDIATRICS**  
**1555 MEDICAL DRIVE - POTTSTOWN PA 19464**  
**(610) 326-7820**

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_