Blanchard Valley Medical Associates

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

Nickname:_____ **Date of Birth:** _____/_____/_____ **Sex:** *(circle one)* M / F

Social Security Number: _____-_____-_____ **Marital Status:** *(circle one)* M / S / D / W

Race: *(circle one)*		**Ethnicity:** *(circle one)*
American Indian/Alaska Native	Black/African American	Hispanic/Latino
Hawaiian/Pacific Islander	Other Race	Not Hispanic/Latino
Asian	White	Decline to Answer
Decline to Answer		

Address: _____ **City / State / Zip**: _____

Home #: ( )_____-_____ **Work #:** ( )_____-_____ **Cell #:** ( )_____-_____

E-Mail:_____ **Preferred Phone Number:** *(circle one)* Home # / Work # / Cell #

Family Doctor:_____ **Referring Doctor:**_____

Employer:_____ **Appt. Reminder Preference:** *(circle one)* Phone / Text / E-Mail

HIPAA RELEASE

I authorize BVMA to contact me regarding my medical information by the following means: *(circle an answer for **each**)*

Home Phone: Yes / No **Cell Phone:** Yes / No **Work Phone:** Yes / No

Answering Machine: Yes / No **Cell Voicemail:** Yes / No **Work Voicemail:** Yes / No

People I authorize to receive my medical information ***(list primary EMERGENCY CONTACT first):***

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

_____ _____

Patient / Guardian Signature Date

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to the Doctor or Group indicated on the claim for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named Doctor or Group any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. I acknowledge and agree that I have received a copy of Blanchard Valley Medical Associates' Notice of Privacy Practices and Financial Policy.

A copy of this signature is as valid as the original.

_____ _____

Patient / Guardian Signature Date