



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: \_\_\_\_\_ Apt. Reminder Preference: (circle one) Phone / Text / E-Mail

*\*If you have an Advance Directive, please submit a copy to us to ensure that it becomes a permanent part of your medical chart.*

**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. Our practice issues monthly itemized statements to patients/guarantors for services rendered.

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