Behm Family Practice, LLC

2500 Brooktree Rd., Suite 200, Wexford, PA 15090
Phone 724-940-0300 Fax 724-940-0301

PATIENT REGISTRATION FORM
Please Print

Last Name:_____

First Name:_____

Middle Name:_____

Other names used:_____

Address 1:_____

Address2:_____

City:_____

State:_____Zip Code:_____

Date of Birth:_____

Sex: M or F other_____

Mobile Phone:_____

Home/Other Phone:_____

Patient Email: _____

Required by Government Mandate: (You may refuse to answer:)

Primary Language:_____

Race:_____

Marital Status: _____

Sexual preference: Heterosexual, Homosexual, Bisexual, Other _____
Assigned Sex at birth: Male Female
Pronouns: he/him she/her they/them

Preferred Lab:_____
Lab Location: _____
Pharmacy Name:_____
Pharmacy Location:_____
Mail Order Pharmacy Name:_____
Contact Preferences: Home Phone, Mobile Phone, Patient Portal, other _____
Emergency Contact
Name:_____
Relationship:_____
Phone: _____

Insurance Information

Primary Insurance Plan Name:

Type of plan: Medicare Replacement, PPO, EPO, HMO, Indeminity, Other_____

Address:_____
_____

City:_____

State:_____ Zip Code: _____

Policy Holder Information

Name:_____

Date of Birth:_____

Relationship to patient:_____

Secondary Insurance Plan Name:

Type of plan Medicare Replacement, Medicare Supplement, PPO, EPO, HMO, Indemnity, Other_____

Address:_____
_____

City:_____

State:_____ Zip Code: _____

Policy Holder Information

Name:_____

Date of Birth:_____

Relationship to Patient:_____

To the best of my knowledge the above information is complete and accurate.

Print Name: _____

Sign Name:: _____

Relationship to patient:*(Required if someone other than patient is completing this form.)*

_____

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ACKNOWLEDGEMENT AND AUTHORIZATION: Please sign

- **I have read and understand the HIPAA/Privacy Policy and Financal Policy for Behm Family Practice, LLC**

  Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provide and authorize Behm Family Practice, LLC to release medical information required to process my claim.**

  Signed_____ **Date:**_____

- **I authorize Behm Family Practice, LLC to obtain/have access to my medication and medical health history and share medical history with other physician care locations.**

  Signed_____ **Date:**_____

- **I authorize Behm Family Practice, LLC to take my photograph or import my photo from my drivers license or photo ID to add to my patient chart for identification.**

  Signed_____ **Date:**_____

Please return this with your office visit or prior to your office visit.

Provide a copy of the front and back of your drivers license and insurance card with this registration form if mailing it to our office or present it to the receptionist at your appointment