

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, Indemnity, 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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PATIENT REGISTRATION FORM

ACKNOWLEDGEMENT AND AUTHORIZATION: Please sign

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

Signed _____ Date: _____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider.

Signed _____ Date: _____

- I authorize Behm Family Practice, LLC to release medical information required to process my claim.

Signed _____ Date: _____

- I have read and understand the Financial Policy for {{MEDICALGROUPBILLINGNAME}}.

Signed _____ Date: _____

- I authorize Behm Family Practice, LLC to obtain/have access to my medication history and share medical history with connected at connected 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