BRADFORD FAMILY MEDICINE, INC.
14 North Third Street, Bradford, Pennsylvania 16702
Phone: (814) 362-6962 Fax: (814) 362-4956

Patient Information Sheet

Patient Name:_____ **SS#:**_____**Date of Birth:**_____
(Last) (First) (MI)
Address:_____**City:**_____**State:**_____**Zip:**_____

Mobile Phone:_____**Home Phone:**_____**Work Phone:**_____

Email Address:_____**Marital Status:**_____**Student:**_____

Place of Employment:_____**Address:**_____

Primary Insurance:_____**Phone:**_____
Address:_____
Identification #:_____**Group #:**_____**Authorization #:**_____
Subscriber Name:_____**Date of Birth:**_____
Subscriber Employer Name/Address:_____

Secondary Insurance:_____**Phone:**_____
Address:_____
Identification #:_____**Group #:**_____**Authorization #:**_____
Subscriber Name:_____**Date of Birth:**_____
Subscriber Employer Name/Address:_____

Other physicians you may be seeing:_____
Did a physician refer you to us? ___Yes___No. If yes, name:_____
How did you hear about us?_____

PATIENT'S NAME:_____**HIC#**_____
I request that payment of authorized Medicare or insurance benefits be made either to me or on my behalf to my physician practice for any services furnished me by physician or supplier. I authorize my holder of medical information about me to release to the Health Care Financing Administration and its agency for information needed to determine these benefits payable for related services.

I AUTHORIZE THE RELEASE OF ANY INFORMATION including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor of practice, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____**Date:**_____
Patient or Authorized Person's Signature

PERMISSION FOR DIANOSTIC PROCEDURES/TREATMENT: I hereby give permission for the staff and personnel at my physician practice to perform such diagnostic studies, to render treatment.

_____
Patient or Responsible Party **Date** **Witness**

_____ **Emergency Contact:**_____
Relationship to Patient **Relationship:**_____**Phone:**_____

Emergency Contact:_____
Relationship:_____**Phone:**_____