Blossomwood Medical
primary care for adults

New Patient Registration

Name: _____ DOB: _____ Age: _____
Preferred Name: _____ Sex: Female / Male / Transgender
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Secondary Phone: _____
SSN: _____ Primary Language: _____ Race: _____
Employer: _____ Occupation: _____
Marital Status: Married Single Divorced Widowed Other _____
Spouse's Name: _____ Spouse's Employer: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____
Last Primary Care Physician? _____
How did you hear about us? _____

PRIMARY INSURANCE INFORMATION:

Cardholder's Name: _____ Cardholder's DOB: _____
Relationship to patient: _____ Sex: _____ SSN: _____
Member ID#: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Cardholder's Name: _____ Cardholder's DOB: _____
Relationship to patient: _____ Sex: _____ SSN: _____
Member ID#: _____ Group #: _____

If Blossomwood Medical is a provider for your insurance company, the guarantor or responsible party for the patient's account will be required to pay all co-pays and/or deductibles as outlines in their insurance policy. For all other insurance companies, guarantor or responsible party will be 100% responsible for charges incurred for all services rendered according to Blossomwood Medicals fee schedule.

I hereby authorize payment of medical benefits directly to physician of benefits due me or my dependents for services rendered. I further authorize the physician to release and information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. Should any account become delinquent, I will be responsible for any collection, attorney, court, or other fees.

_____ _____

Signature **Date**