EvershineMED
Bedford Family Medicine

PATIENT REGISTRATION

Please Print

Patient Name (First, Middle, Last): _____

Date of Birth: _____ Social Security Number: _____

Ethnicity: ○ Hispanic ○ Non-Hispanic	Race: ○ White ○ Black ○ Asian ○ Hawaiian ○ Other _____
Sex at birth: ○ Male ○ Female ○ Other _____ ○ Decline to answer	Gender Identity: ○ Male ○ Female ○ Transgender Female ○ Transgender Male ○ Gender Queer ○ Other _____ ○ Decline to answer
Preferred Pronouns: ○ He/him/his ○ She/her/hers ○ They/them/theirs ○ Other _____	

Home Address: _____

City, State, Zip: _____

Who can we thank for referring you to us? _____

Patient Name (First, Middle, Last): _____

Preferred Phone Number: _____ Ok to leave message? ○ Yes ○ No	Alternate Phone Number: _____ Ok to leave message? ○ Yes ○ No

Email Address: _____ Would you like to join our portal? o Yes o No	Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
Employer: _____ Job Title: _____	

Insurance Information

Primary Insurance	Secondary Insurance
Company Name:	Company Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Insured's Name:	Insured's Name:
Relationship to Patient:	Relationship to Patient:
Insured's Birth Date:	Insured's Birth Date:
ID Number:	ID Number:
Group Number:	Group Number:

Credit Card/HSA Card Number (to keep on file for co-pays, deductibles, outstanding balances):

Number: _____ Expiration Date: _____

Name on Card: _____ Security Code: _____

**A copy of your state issued photo identification card or driver's license is required. **

I hereby authorize payments of medical benefits directly to the physician. I also understand I am responsible for any portion of my bill not covered by my insurance company. I hereby release the information for insurance claim purposes. I have read and understand all of the above and hereby state that the information is correct to the best of my knowledge.

Patient or Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____