BROOKSIDE FAMILY PRACTICE & PEDIATRICS
1555 MEDICAL DRIVE - POTTSTOWN PA 19464
(610) 326-7820

PATIENT REGISTRATION

Patient Name ____
Patient Address ____
City ____________________State ______Zip Code _________Patient Telephone ________________________
Patient Birthdate ____/____/____ Sex: M ___ F ___ Patient Social Security Number ______________________
Patient Status: Single ___ Married ___ Other ____ Employed ____ Full-time Student ____ Part-time Student ____
Employer/School Name ____
Employer/School Address ____
City __________________________State ____________________Zip Code ____________________
Condition Related To:Employment Yes ___No ___ Auto Accident Yes ___No ___ Other Accident Yes ___No ___
Emergency Telephone ___________________________ Emergency Party ___________________________
Send Bills To ____
Billing Address ____
City ___________________________________State __________________Zip Code __________________
Referring Physician: ____

Primary Insurance ____
Policy/Agreement/ID Number ______________________________Group Number ______________________
Insured Name ____
Insured Address ____
City ______________________State _______Zip Code ____________Insured Telephone _________________
Insured Birthdate ____/____/____ Sex: M ___F___ Insured Social Security Number ______________________
Insured Employer Name ____
Insured Employer Address ____
City __________________________________State __________Zip Code _________________________
Relationship: Self ___ Spouse ___Child ___ Other ___

Secondary Insurance ____
Policy/Agreement/ID Number ___________________________Group Number _________________________
Insured Name ____
Insured Address ____
City _______________________State _____Zip Code _____________Insured Telephone ________________
Insured Birthdate ____/____/____ Sex: M ___F___ Insured Social Security Number _______________________
Insured Employer Name ____
Insured Employer Address ____
City ___________________________________State __________________Zip Code
Relationship: Self ____Spouse ____Child ____Other ____

Other Insurance ____
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I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plan to Pottstown Medical Specialists, Inc.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient or Authorized Person ________________________________Date ______/______/______