PMSI
COMPREHENSIVE HEALTHCARE
For Life

PMSI DIVISION OF RHEUMATOLOGY & INFUSION CENTER
1566 Medical Drive, Suite 104
POTTSTOWN, PA 19464, P: 484-945-0075

PATIENT REGISTRATION

Patient Name _____ Date of Birth: _____
Patient Address _____
City _____ State _____ Zip Code _____ Home Phone: _____
Sex: M ___ F ___ Last 4 digits of SS#: _____ Cell Phone: _____
Patient Status: Single ___ Married ___ Other ____
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 ____

Primary Care Provider: _____
Referring Provider: _____

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 _____/_____/_____