BECKFORD MEDICAL CENTER

○ *Henderson* ○ *Warrenton* ○ *Centerville*

PATIENT INFORMATION & REGISTRATION FORM

DATE: _____

Patient Name: _____
First **Middle** **Last**

Mailing Address: _____
Street **City** **State** **ZIP Code**

Date of Birth: ____/____/_____ **Age:** _____ **Social Security Number:** _____-_____-_____

Phone Number: ( )_____-_____ **Mobile Number:** ( )_____-_____

Email Address: _____

Do you AUTHORIZE the providers and staff of this clinic to leave details of your personal health information in your voicemail box or answering machine? _____*YES* _____*NO*

If YES: Signature: _____ ***Preferred Phone No.***_____

Responsible Party IF Patient is a Minor

Name: _____
First **Middle** **Last**

Address: _____
Street **City** **State** **ZIP Code**

Date of Birth: _____/_____/_____ **Age:** _____ **Social Security Number:** _____-_____-_____

Phone Number: ( )_____-_____ **Mobile Number:** ( )_____-_____

Email Address: _____

Relationship to Patient: _____

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INSURANCE INFORMATION: Please check all that applies:

Medicaid:_____ **Medicare:** _____ **BCBS** _____ **Other:** _____

Insurance ID Number: _____

MODE OF PAYMENT:

Cash: _____ **Check:** _____ **Credit Card:** _____ **Other:** _____

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