B·G·I·M·P
BG Internal Medicine
& Pediatric Associates

PATIENT DEMOGRAPHIC INFORMATION – 18 YEARS AND OLDER

Patient's Name: _____ **Sex:** M / F **DOB:** ____/____/_____

Address: _____

Street

_____

City State Zip

Your Cell Phone: (_____) _____ **Your Work Phone:** (_____) _____

Insurance: _____ **Policy Holder:** _____

Guardian # 1 Name: _____ **Relationship:** _____

Address: _____

Street

_____

City State Zip

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Guardian # 2 Name: _____ **Relationship:** _____

Address: _____

Street

_____

City State Zip

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Authorization for Treatment and Release of Information

I authorize BGIMP to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment, BGIMP has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care. _____ **INITIAL**

Acknowledge of Receipt of Consent to Use and Disclose Health Information

I acknowledge that I have received the Consent to Use & Disclose Health Information, which explains how my health information will be handled in various situations. _____ **INITIAL**

ATTENTION

Though you may still be covered under your parent's insurance, you, as an adult, are solely financially responsible for any and all payments: copay, coinsurance, or deductible that your insurance deems as your responsibility.

My signature below indicates I am the patient listed above, that I have provided accurate information to the best of my knowledge and I understand and agree to the provision above.

_____ _____

Signature **Date**