BUFFALO MEDICAL GROUP
PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

Patient Last Name; First; M.I._____
SS# _____-_____-_____ *(optional)* Birth Date _____ /_____ /_____ Sex: (Circle One) M or F
Address: _____
City: _____ State: _____ Zip: _____
Home Phone ( ) _____ - _____ Work Phone ( ) _____ - _____ Cell Phone ( )____-_____

REFERRING PHYSICIAN

Referring Physician: _____ Phone #: _____
Primary Care Physician: _____ Phone #: _____

EMPLOYER

Employer Name: _____ Phone #: _____
Employer Address:_____ Occupation:_____

****If Spouse insurance is primary over Medicare, please complete the following:**
Name of Spouse Employer: _____ Spouse DOB: ____/_____/_____
Spouse Employer Address:_____

EMERGENCY CONTACT

Emergency Contact: _____
Relationship to Patient: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip: _____

INSURANCE

Primary Ins: _____ ID. #: _____
Policy Holder: _____ Group #: _____
Relationship to Patient: _____
Secondary Ins: _____ ID. # _____
Policy Holder: _____ Group #: _____
Relationship to Patient: _____

Is this a Worker's Compensation Case? Yes.____ No ____ **No Fault?** Yes ____ No____
Case # or Policy # _____ Date of Accident: _____/_____/_____
Insurance Carrier: _____
Insurance Carrier Address:_____

Direct Payment Request and Authorization to Release Medical Information

"I hereby authorize the release of information acquired during the course of my examination and treatment to the CMS and its' agents, or any other third party carrier as necessary to secure payment of any benefits due to me, I hereby assign payment of said benefits to include Medicare benefits directly to my physician. I understand that I am responsible for all charges regardless of insurance status, as well as any associated costs for collection should such action become necessary, I agree that this authorization shall, be valid until canceled in writing or replaced by one of a later date. A photocopy of this assignment shall, be considered as valid as the original. I authorize the Group, its physicians, medical personnel, staff and agents to render all medical treatment that is considered appropriate and necessary. I have read the above and fully understand the terms thereof."

_____

Patient Signature **Date**