BUSINESS OFFICE USE ONLY
CHECKED IN COMPUTER_____(init.) COPAY_____ PATIENT #_____
COPY SENT TO BILLING_____(date) DIAGNOSIS 1 _____
DIAGNOSIS 2 _____

TODAYS DATE_____

PATIENT INFORMATION

LAST NAME_____FIRST NAME_____DOB_____AGE_____

SEX_____MARITAL STATUS_____ RACE _____

ETHNICITY_____ COUNTRY OF ORIGIN _____

PRIMARY LANGUAGE _____E-MAIL ADDRESS_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (H)_(____ __)_____(W)_(_____)_____(C)__(____ _)_____

PREFERRED METHOD OF CONTACT FOR **APPOINTMENT REMINDERS:**
_____ TEXT MESSAGE_____ VOICE PHONE CALL_____ EMAIL (Check all that apply)

EMPLOYER NAME _____
PRIMARY CARE CLINIC_____

Who referred you to our clinic?
O-Primary care Doctor- Name_____ Clinic_____
O- Specialist- Name_____ Clinic_____
O- Insurance Company- Name_____
O- BHSI web site O- Other web site- Name _____
O- Family member O- Friend O- Former/Current client-O- Yellow pages O- Self referred
O-Other _____

INSURANCE INFORMATION
SUBSCRIBER/INSURED'S NAME_____DOB_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (H)__(_____)_____(W)_(_____)_____

GROUP #_____ID#_____

EFFECTIVE DATE_____RELATIONSHIP TO SUBSCRIBER_____

DO YOU HAVE SECONDARY INSURANCE_____YES_____NO NAME_____
RESPONSIBLE PARTY (Person responsible for account)

NAME_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE H)_(_____)_____(W)_(_____)_____

EMPLOYER NAME_____DOB_____