

Broadway Medical Clinic, LLP

PHYSICIANS & SURGEONS



Patient Profile

Medical Record Number: 12345

Patient Legal Last Name: Mai	First Name: bui	Middle Initial:	Previous Name/Nickname:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:				
City:	State:	Zip:	Social Security Number:	Date of Birth:
Primary Phone Number: <input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Work <input checked="" type="checkbox"/> Cell		Secondary Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Other Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Email Address:	Employer Name: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No
Referring Physician:	Address:		Phone Number:	
Guarantor Name (if other than patient):	Patient Relationship to Guarantor: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Dependent <input type="checkbox"/> Other		Guarantor Date of Birth:	
Address (if different than patient):		Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		
Insurance Information				
Primary Insurance Company:		Secondary Insurance Company:		
Address:		Address:		
Insured ID:	Policy Group #:	Insured ID:	Policy Group #:	
Group Name or Employer:	Relation to Insured:	Group Name or Employer:	Relation to Insured:	
Insured Name (if other than patient):	Insured Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Insured Name (if other than patient):	Insured Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Insured Social Security Number:	Insured Date of Birth:	Insured Social Security Number:	Insured Date of Birth:	
Emergency Contact Information				
Name:	Phone Number(s):	Relationship:		
Name:	Phone Number(s):	Relationship:		

How did you hear about Broadway Medical Clinic?

- ☐ Other Doctor
 ☐ Online
 ☐ Publication
 ☐ Insurance Company
 ☐ Friend/Family member
 ☐ Other _____

Race? (Federal Statistics and Administration reporting for medical research purposes)

- ☐ I decline to answer
 ☐ American Indian or Alaska Native
 ☐ Asian
 ☐ Other
 ☐ Native Hawaiian or Pacific Islander
 ☐ Black or African American
 ☐ White

Ethnicity? (Federal Statistics and Administration reporting for medical research purposes)

- ☐ I decline to answer
 ☐ Hispanic or Latino
 ☐ Not Hispanic or Latino

Preferred Language? _____

☐ Interpreter needed

Patient Initials

MB

Broadway Medical Clinic, LLP

PHYSICIANS & SURGEONS

Always Smile

Broadway Medical Clinic, LLP (BMC)

Consents, Releases, and Agreements

Patient Name

mai

Date of Birth

P202203062108ML

Notice of Uses and Disclosures of Protected health Information

I acknowledge that I have been provided with BMC Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations of BMC as well as my individual rights and the duties of BMC with respect to my protected health information.

I understand that BMC may use or disclose my protected health information to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. "Protected health information" includes information created, maintained, or received by BMC that identifies me, or from which my identity could be determined, and which relates to my past, present, or future physical or mental health, condition, treatment, or payments for medical services.

BMC reserves the right to change the privacy practices that are described in its notice of Privacy Practices. BMC will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting BMC and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature

mai

Date

Financial Agreement and Assignment of Benefits:

Medicare & Medicaid: I request that payment under the medical insurance program be made either to me or to Broadway Medical Clinic (BMC) on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim.

All other Payors: I authorize payment directly to BMC of all benefits otherwise payable by any insurance policy(s) and I hereby irrevocably assign such benefits to BMC in an amount not to exceed the charges for services rendered.

I agree to be financially responsible for the balance left after processing by my insurance. If not covered by insurance, I agree to be financially responsible for services rendered. If I am unable to pay in full, I understand that a payment plan may be established.

Patient Signature

mai

Date

P202203062108ML