Registration: **Date**: ______________________________

Patient First name:__________________________________Last:____________________________________

DOB: _____/_____/_____ Age:______ Gender: Male _____ Female ______ Prefers Not to Answer________

Patient's Home Adress:____

City:____State________________ Zip Code:_________________

Patient's Cell (_____)____________________ Patient's email____

Parent/Guardian: ____ Cell (_____)_____________________

Parent/Guardian: ____ Cell (_____)_____________________

Billing Address (*if different from above):* ____

City: __________________________________ State: _______________________ Zip code: _____________

Home Tel # (______)______________________Preferred Email: _____________________________________

Insurance Information:

Primary Insurance Plan Name: ____
Policy Number: ________________________________ Group Number: _______________________________
Primary Policy Holders Name:____ DOB: ____________
Relationship to Patient: __________________ Employer: ____

Financially Responsible Party:

Name ____ Phone/Cell (______)____________________

Release of Information and Assignment of Benefits
I hereby authorize *Bridgespan Medicine PLLC* to release information concerning treatment or services rendered to Medicare and other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare and other insurance company benefits be made to me or on my behalf to Bridgedpan Medicine, PLLC for all services rendered. I have been advised that if my insurance requires a co-pay, it is due at the time of the visit to avoid a late fee of $20 added to my bill.

Signature of Parent /Guardian____ Date: ____________

SW:10.19