BELMONT MEDICAL ASSOCIATES, INC.

PATIENT INFORMATION FORM

☐ NEW PATIENT
☐ DEMOGRAPHIC CHANGE
☐ INSURANCE CHANGE

☐ A. Kahn	☐ M.K. Dy	☐ O. Minkoff	☐ A. Shushan
☐ C. Barsam	☐ B. Goldbaum	☐ C. Mintzer	☐ J. Sinden
☐ K. Bernstein	☐ M. Green	☐ E. Mostone	☐ C. Taffe
☐ N. Coconcea	☐ K. Kane	☐ G. Szentpaly	☐ R. Tirado
☐ J. Danchik	☐ T. Kaye	☐ V. Palazzo	☐ F. Wirth
☐ J. Datu	☐ E. Kowaloff	☐ D. Pelletier	☐
☐ D. Davidson	☐ C. McLaughlin	☐ S. Ranere	☐

Demographics: (PLEASE PRINT CLEARLY)

First Name:	Last Name:	MIDDLE:
Maiden/Previous:	D.O.B:	SS#:
Gender: ☐ MALE ☐ FEMALE ☐ TRANSGENDER		

Street:	City:	State:	Zip:
Home Phone:	Work Phone:	Mobile Phone:	
Patient Email Address:			
Emergency Contact:	Emergency phone:		

Ethnicity, Race & Language: (PLEASE CIRCLE ONE FROM EACH LINE)

1. Hispanic or Latino Non-Hispanic or Latino
2. Black or African American Asian White/Caucasian American Indian Other_____
3. Primary Language: English Spanish Portuguese Other _____

Primary Care Physician (PCP) - For Belmont Medical PCPs, please check a box on top of this page

Primary Care Physician**:**	PCP Phone:
Primary Care Physician Address:	

Insurance: PRIMARY

Insurance Plan:	Member ID:	
Group No.:	Subscriber Name (if other than self):	
Your relationship to subscriber (circle): SELF SPOUSE CHILD LIFE PARTNER		Subscriber D.O.B.:

Insurance: SECONDARY

Insurance Plan:	Member ID:	
Group No.:	Subscriber Name (if other than self):	
Your relationship to subscriber (circle): SELF SPOUSE CHILD LIFE PARTNER		Subscriber D.O.B.:

PICTURE OF INSURANCE CARD FRONT	**PICTURE OF INSURANCE CARD BACK**

Pharmacy Information:

Name of Pharmacy:		
Street:	City:	State:
Zip:	Phone:	Fax:

INSURANCE AUTHORIZATION & ASSIGNMENT: *I hereby authorize Belmont Medical Associates, Inc. to furnish information to my insurance carrier(s) concerning my health information regarding my illness and treatment. I hereby assign to the physician(s) all payments for medical service for myself and/or my dependents. I understand I am responsible for any amount not covered by my insurance contract.*

I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY CLAIM THAT HAS BEEN DENIED BY MY INSURANCE DUE TO LACK OF REFERRAL OR ANY SIGNIFICANT INSURANCE INFORMATION DEEMED NECESSARY TO FILE A CLAIM ON MY BEHALF.

IF MY INSURANCE CHANGES IT IS MY RESPONSIBILITY TO UPDATE IT WITH BELMONT MEDICAL ASSOCIATES AS SOON AS POSSIBLE. IF I DO NOT UPDATE MY INSURANCE INFORMATION RIGHT AWAY AND DO SO AT A LATER DATE AND IT IS NOT WITHIN CLAIM FILING LIMITS AND A CLAIM IS SUBMITTED TO MY NEW INSURANCE AT THAT TIME AND IS DENIED FOR TIMLEY FILING I WILL BE RESPONSIBLE FOR FULL PAYMENT.

SIGNATURE OF PATIENT/PARENT/GUARDIAN:_____DATE:_____

PRINTED NAME OF PATIENT _____