Foothills Medical Group
Bradford Regional Medical Center

Patient Information

Patient Name: _____ DOB: ___/___/_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ____-____-_____Work/Cell Phone: ____-____-_____ Ext:____

Social Security: _____ Gender: M – F

Primary Care Physician: _____

Email Address (for Patient Portal) _____

Primary Pharmacy: _____ Location: _____

May we leave a message? Yes or No

Emergency Contact:

Name: _____ Phone: ____-____-_____

Relationship to Patient: _____

Financially Responsible Party (If different from Patient):

Responsible Party Name: _____

Street Address: _____City:_____ State: _____

Home Phone: ____-____-_____ Date of Birth: ___/___/_____ Gender: M – F

The signature below is my authorization for the release of information necessary to my primary care, referring physician's office, and/or consultants if needed, and as necessary to process insurance claims, obtain pre-authorizations or pre-certifications for treatment, process insurance applications, and obtain prescriptions. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for a Medicare claim.

I also understand that I am responsible for payment in full for services rendered. I permit a copy of this authorization to use in place of the original. For Medicare, I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31
U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature: _____ Date: _____