

# Broadway Medical Clinic, LLP

PHYSICIANS & SURGEONS

## Patient Profile

Medical Record Number: \_\_\_\_\_

Patient Legal Last Name:	First Name:	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 type="checkbox"/> Home <input type="checkbox"/> Work <input 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	
<b>Insurance Information</b>				
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:	
<b>Emergency Contact Information</b>				
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 \_\_\_\_\_

Broadway Medical Clinic, LLP  
PHYSICIANS & SURGEONS

**Broadway Medical Clinic, LLP (BMC)**  
**Consents, Releases, and Agreements**

Patient Name	Date of Birth
--------------	---------------

***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	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	Date
-------------------	------