BUFFALO MEDICAL GROUP

PATIENT REGISTRATION FORM

REQUIRED

Patient Name (Last, First, M.I.) _____

SSN# (optional) ____ - ____ - ____ Birth Date: ____ - ____ - ____

Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: ( ) - Cell Phone: ( ) -

Primary? ☐ Yes ☐ No Primary? ☐ Yes ☐ No

Email: _____

In order to comply with the Center for Medicare and Medicaid Services (CMS) Meaningful Use for quality standards, Buffalo Medical Group (BMG) needs your assistance in gathering the following additional demographic information on our patients:

OPTIONAL

Race: ☐ Black or African American ☐ American Indian/Eskimo ☐ Asian/Pacific Islander ☐ Caucasian ☐ Native Hawaiian ☐ Multi-Racial ☐ Hispanic/Latino ☐ Prefer not to answer ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Preferred Language ☐ English ☐ Flemish ☐ Greek ☐ Japanese ☐ Portuguese ☐ Swedish ☐ Chinese ☐ French ☐ Hebrew ☐ Norwegian ☐ Russian ☐ Other ☐ Dutch ☐ German ☐ Italian ☐ Polish ☐ Spanish

Employer Name: _____ Employment Status: _____

Emergency Contact: _____ Relation to patient: _____

Address: _____ Phone Number: ( ) -

City: _____ State: _____ Zip: _____

REQUIRED

Is this a Worker's Comp Case? ☐ Yes ☐ No No Fault? ☐ Yes ☐ No

Case/Policy #: _____ Date of Accident: _____

Insurance Carrier: _____

Carrier Address: _____

Communication Preference: ☐ Home Phone ☐ Cell Phone ☐ Mail

If patient is under 20 years old, please provide Mother's maiden name for New York State's immunization Registry:

_____

Direct Payment Request and Authorization to Release Medical Information

"I hereby authorize the release of information acquired during the course of my examination and treatment to the CMS and its' agents, or any other third party carrier as necessary to secure payment of any benefits due to me, I hereby assign payment of said benefits to include Medicare benefits directly to my physician. I understand that I am responsible for all charges regardless of insurance status, as well as any associated costs for collection should such action become necessary, I agree that this authorization shall, be valid until canceled in writing or replaced by one of a later date. A photocopy of this assignment shall, be considered as valid as the original. I authorize the Group, its physicians, medical personnel, staff and agents to render all medical treatment that is considered appropriate and necessary. I have read the above and fully understand the terms thereof."

Patient Signature: _____ Date: _____