| 3 Gorham Rd | Pembroke HM08 Bermuda | [P] 441-292-4530 | [F] 441-295-1279

PATIENT INFORMATION PLEASE PRINT CLEARLY

Last Name: _____ First Name: _____ Middle: _____

Martial Status: (Please Circle) M S D W | Gender: (Please Circle) Male Female |

Who referred you? or How did you hear about BWOC ?_____

Mailing Address: _____

P.O. Box: _____

Parish: _____ Zip Code: _____

Telephone Numbers: Primary Number (Please Tick One) ☐ Home | ☐ Work | ☐ Cell

Home:_____ Work: _____ Cell: _____ Fax:_____

Email Address:_____ Date of Birth: (Please Print Month) _____/_____/_____
Month Day Year

Employer: _____

Employer Address: _____

POLICY HOLDER (If Different Than Above) Relation to patient: (Please Circle) Parent Spouse Self Other: (Specify)_____

Last Name:_____ First Name: _____ Middle:_____

Mailing Address: _____
(If same as above information, indicate same as above)

P.O. Box: _____

Parish:_____ Zip code: _____

Telephone Numbers: Primary Number (Please Tick One) ☐ Home | ☐ Work | ☐ Cell

Home:_____ Work: _____ Cell: _____ Fax:_____

Email Address:_____ Date of Birth: (Please Print Month) _____/_____/_____
Month Day Year

Employer: _____

INSURANCE INFORMATION: (PLEASE CIRCLE INSURANCE COMPANY)

Argus | BFM | GEHI | GEHI 100% | HIP | HIP for >BFM; SIIC; COL | Cash | Future Care | Colonial

(Note: We issue a claim to your insurance company, You pay the difference at the time of your appointment)

Group/Policy# _____ Certificate # _____ Insurance effective Date: _____

I, the undersigned, hereby authorize payment of insurance benefits to the attending Provider for the service/s rendered to the patient named on this form, together with the release of any medical information necessary to process a medical claim.

I, understand that I am solely responsible for full payment of all cost/s incurred in the event that my insurance company does not pay, as well as all legal cost from an agency collection if charges are not paid and any expense that may be charged for collection of an outstanding account/s.

Guarantor's Name (**please print**):_____
(If you are a minor, this must be signed by your parent/guardian.)

Signature of Guarantor: _____ Dated: _____

Emergency Contact name and number along with type of relationship to you the patient:

_____