115 Professional Drive, Suite 104, Ponte Vedra Beach, FL 32082
P-904-930-4774 | F-904-647-2476 | www.BalancedPhysicianCare.com
Direct Primary Care - Integrative Medicine - Sports Medicine - Family Medicine -

Patient Registration Form

Today's Date:

Patient Information		
Patient Name: (last, first, middle)	**(maiden)**	
Preferred Name:		
Date of Birth:		**Age:**
Social Security #:		
Gender:	☐ **Male**	☐ **Female**
Patient Address:		
City	**State**	**Zip Code**
Home Phone:		
Cell Phone:		
Work Phone (optional):		
Email:		
How did you hear about us?:		
Communication Options:		
Mobile text notifcations:	☐ **Yes**	☐ **No**
Voice notifications:	☐ **Yes**	☐ **No**
Email notifications	☐ **Yes**	☐ **No**
May we leave a private message on your voice mail?	☐ **Yes**	☐ **No**
What phone number may we use to leave you a private message?:		

Preferred method of communication for items below: (Email, Phone, Text)	
General medical information (such as normal lab test results):	
Emergency communication:	
General office communication (non-medical): Appointment Reminders, Office Closings, Upcoming Workshops, Etc.	

Payment Information		
BPC Member:	☐ **Yes**	☐ **No**
Self-Pay:	☐ **Yes**	☐ **No**
Medicare:	☐ **Yes**	☐ **No**

Insurance or Medicare information		
Beneficiary Name:		
Policy Number & Group Number:		
Effective Date:	**Expiration Date:**	
Do you have Medicare secondary insurance?	☐ **Yes**	☐ **No**

Policy Holder of Insurance		
What is your relationship to the Policy Holder?		
Policy Holder Name (last, first, middle)		
Date of Birth	**Social Security #:**	
Address:		
City	**State**	**Zip Code**
Gender:	☐ **Male**	☐ **Female**
Primary Phone Number:		
Secondary Phone Number:		

Pharmacy
Name of Preferred Pharmacy:
Address:
Phone Number:

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Emergency Contact		
Name: (last, first, middle)		
Primary Phone Number:		
Secondary Phone Number:		
Relationship To Patient:		
Address:		
City	**State**	**Zip Code**
Is the the same person as your "Medical Next of Kin"? **If "No", then complete Medical Next of Kin section**	☐ **Yes**	☐ **No**

Medical Next of Kin/ Health Care Power of Attorney		
Name: (last, first, middle)		
Primary Phone Number:		
Secondary Phone Number:		
Relationship To Patient:		
Address:		
City	**State**	**Zip Code**

Immunization Registry		
May we download Immunization Records from state & federal registries?	☐ **Yes**	☐ **No**