Broadway Medical Clinic, LLP
PHYSICIANS & SURGEONS

Patient Profile

Medical Record Number:_____

Patient Legal Last Name:	**First Name:**	**Middle Initial:**	**Previous Name/Nickname:**	**Gender:** ☐Male ☐Female
Address:				
City:	**State:**	**Zip:**	**Social Security Number:**	**Date of Birth:**
Primary Phone Number: ☐Home ☐Work ☐Cell	**Secondary Phone Number:** ☐Home ☐Work ☐Cell	**Other Phone Number:** ☐Home ☐Work ☐Cell		
Email Address:	**Employer Name:** ☐ Employed ☐ Unemployed ☐ Retired ☐ Student	**Marital Status:** ☐ Single ☐ Married	**Smoker:** ☐ Yes ☐ No	
Referring Physician:	**Address:**	**Phone Number:**		
Guarantor Name (if other than patient):	**Patient Relationship to Guarantor:** ☐ Spouse/Partner ☐ Child ☐ Dependent ☐ Other	**Guarantor Date of Birth:**		
Address (if different than patient):	**Phone Number:** ☐Home ☐Work ☐Cell			

Insurance Information

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:** ☐ Male ☐ Female	**Insured Name (if other than patient):**	**Insured Gender:** ☐ Male ☐ Female
Insured Social Security Number:	**Insured Date of Birth:**	**Insured Social Security Number:**	**Insured Date of Birth:**

Emergency Contact Information

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