SHARE

HMC
BURNABY URGENT CARE
& MEDICAL IMAGING

PATIENT INFORMATION

Fax this form to 441-295-9935 or email to: info@hmc.bm
Physical Address: 10/12 Burnaby Street, City of Hamilton HM11 Bermuda
Phone: 441-400-8378 - www.hmc.bm

☐MR ☐MRS ☐MISS Patient **LAST** Name _____ Patient **FIRST** Name _____

DOB (DD/MM/YYYY) _____ Mailing Address _____

Parish _____ Post Code _____

Home Phone # _____ Work Phone #_____ Cell Phone # _____

Email Address _____

Place of Employment _____Name of Insurance Company _____

Insurance Policy Number _____ Effective Date (DD/MM/YYYY) _____

Home & Office _____ Major Medical _____

Is this Policy in your name? _____ In not, Who's name is on the Policy?_____

Name of Policy holder (Usually the Employer) _____

Next of Kin _____ Relationship_____ Tel # _____

I, the undersigned, hereby authorise payment of Insurance benefits to the attending Physician and or laboratory for services rendered to the patient named on this form, together with the release of any information necessary to process the claim, and will be responsible for any amount not covered by my insurance.

_____ (DD/MM/YYYY) _____

SIGNATURE OF PATIENT **DATE**