MedStar Medical Group at Old Emmorton Road
2227 Old Emmorton Road, Suite 220
Bel Air, MD 21015
Phone: 410-569-9040, Fax: 844-569-0856

PATIENT REGISTRATION AND AUTHORIZATION FORM

Patient Information:

Name:____DOB:____________
Last Name First Name MI

Street:____ Apt:______________

City:_______________________________________State:_______Zip Code:__________

Home Phone:_______________Work Phone:______________Cell Phone:____________________

Which is the best phone number to reach you? ☐Home ☐Cell ☐Work Ok to leave message on voicemail? ☐yes ☐no

Pharmacy Name and Location:____

Last 4 digits of Social Security #:________Email ________________________________

Patient Employment Information:

Employer:_______________________________________ Occupation:__________________

Street:__________________________________City/State:_____________Zip Code:_______

Work Phone Number:___________

Emergency Contact Information:
Name:____________________________Relationship to Patient:___________

Street:__________________________________City/State:____________Zip Code:________

Home Phone:______________Cell Phone:______________Work Phone:____________________

Authorization To Release Information

ENTER THE NAME(S) OF THE PERSON(S) WHO CAN SPEAK TO US ON YOUR BEHALF

I hereby authorize this medical facility to release any information regarding my treatment, which may include medical issues and care, results of tests, and payment, to the following individuals:

_______________________________________ ________________
_______________________________________ ________________
Name **Relationship**

_______________________________________ ________________
Name **Relationship**

Privacy Practices, Insurance Authorization and Assignment and Advance Directive

Do you have an Advance Directive or Living Will? ☐**Yes** ☐**No**
Would you like information regarding Advance Directive? ☐**Yes** ☐**No**

I acknowledge that I have received the MedStar Health Notice of Privacy Practices Booklet (HIPAA PRIVACY ACT).

I certify that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the patient's representative to sign this document and be bound by its terms. I hereby authorize my physician to furnish to the insurance carriers listed above, my illness and treatments.

Signature:_______________________________________**Date:**________________

Please Note: A copy of your health plan identification card(s) and a photo ID is required. Please give the cards to the receptionist for photocopying and confirmation of benefits. Your cards must be available at each visit. Your co-payment must be paid at the time of service.