MedStar Medical Group

Patient Registration

☐ NEW PATIENT ☐ ESTABLISHED PATIENT	DATE:	PHYSICIAN:	ACCT. #:	OFFICE:	PSC INIT:

GUARANTOR INFORMATION - PERSON RESPONSIBLE FOR PAYMENT

GUARANTOR NAME: *(Last)*	*(First)*	*(MI)*
ADDRESS:		

CITY:	STATE:	ZIP:	SEX: ☐ M ☐ F	EMPLOYED: ☐ YES ☐ NO	EMPLOYER/SCHOOL:

HOME PHONE:	WORK PHONE:	DOB: / /	SOCIAL SEC #:	MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW

RACE: ☐ WHITE ☐ AFRICAN AMER ☐ HISPANIC ☐ ASIAN/PAC ISLANDER ☐ AMER IND ☐ OTHER	REFERRED BY:

PATIENT INFORMATION - IF DIFFERENT FROM GUARANTOR

PATIENT NAME: *(Last)*	*(First)*	*(MI)*
ADDRESS:		

CITY:	STATE:	ZIP:	DOB: / /	SEX: ☐ M ☐ F	RELATION TO GUARANTOR:

HOME PHONE:	WORK PHONE:	SOCIAL SEC #:	REFERRING DR:	MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW

RACE: ☐ WHITE ☐ AFRICAN AMER ☐ HISPANIC ☐ ASIAN/PAC ISLANDER ☐ AMER IND ☐ OTHER	EMPLOYED: ☐ YES ☐ NO	EMPLOYER/SCHOOL:

DO YOU HAVE A LIVING WILL? _____ ☐ YES ☐ NO
IF YES, PLEASE FORWARD A COPY TO THIS OFFICE AND MAKE SURE YOU DISCUSS IT WITH YOUR DOCTOR.

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: *(Last)*	*(First)*	*(MI)*
RELATIONSHIP TO PATIENT:	ADDRESS:	

CITY:	STATE:	ZIP:	PHONE (H):	PHONE (W):

INSURANCE INFORMATION

Please give us all information regarding your coverage. If you have additional health, dental, vision coverage by more than one carrier please supply information on both.

PRIMARY INSURANCE:	SECONDARY INSURANCE:
ADDRESS:	ADDRESS:
GROUP NUMBER OR COMPANY:	GROUP NUMBER OR COMPANY:
EFFECTIVE DATES:	EFFECTIVE DATES:
INSURED ID NUMBER:	INSURED ID NUMBER:
CO-PAY:	CO-PAY:
INSURED'S NAME:	INSURED'S NAME:
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
INSURED'S SS# DOB:	INSURED'S SS# DOB:

ADDITIONAL INFORMATION - Complete this Section Only if Applicable

☐ WORKERS' COMPENSATION ☐ THIRD PARTY LIABILITY ☐ AUTO ACCIDENT

INSURANCE COMPANY:	CLAIM NUMBER:
INSURANCE ADDRESS:	

IF WORKERS' COMPENSATION, NAME AND ADDRESS OF EMPLOYER AT TIME OF INJURY	CONTACT NAME:	PHONE NUMBER:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize my attending physician to furnish information to the insurance carriers listed above concerning my illness and treatments.

SIGNATURE: _____ DATE: _____

I hereby assign to my attending physician all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by insurance at the time of service. I also understand that I am responsible for collection and legal costs should it be necessary for this account to be turned over to a collection agency.

SIGNATURE: _____ DATE: _____