MedStar Medical Group

2003 Medical Parkway, Suite 100, Annapolis, MD 21401
Phone: (410) 573-1110

PATIENT REGISTRATION and AUTHORIZATION FORM

Patient Information:

Name (Last): ______________________ **(First):** _________________________ **(Middle):** ______________

Street: ____ **Apt:** _________________

City: ___________________________________ **State:** __________ **Zip Code:** ____________

Home Phone: ___________________________ **Work Phone:** _____________________________

Cell Phone: _____________________________ **Email:** ___________________________________

Date of Birth: _____________________ **Social Security #:** ________________________

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Hawaiian/Pac Island ☐ Multiracial

Ethnicity: Do you consider yourself Hispanic? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Student: ☐ Yes ☐ No (Skip Employment information if non-applicable)

If Retired or Disabled (no longer working), please provide retirement/disability date: __________________

Patient Employment Information:

Occupation:______________________________ **Employer:** ___________________________

Street:__________________________________ **Suite #:** _____________________________

City:___________________________________ **State:** ______________ **Zip Code:** _____________

Alternative Work Contact Number: _____________________

Emergency Contact Information:

Name: _________________________________ **Relationship to Patient:** ____________________ **Apt:** _____

Street: ________________________________ **State:** ___________________________

City: _________________________________ **Home Phone:** _____________________

Zip Code: ______________________________ **Work Phone:** _____________________

Cell Phone: _____________________________

PATIENT REGISTRATION and AUTHORIZATION FORM

Primary Insurance Information:

Plan Name: ____

Plan ID #: ____

Plan Group #: ______________________________________

Subscriber's name: __________________________________

Subscribers Date of Birth: ___________________________

Subscribers relationship to patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Secondary Insurance Information:

Plan Name: ____

Plan ID #: ____

Plan Group #: ______________________________________

Subscriber's name: __________________________________

Subscribers Date of Birth: ___________________________

Subscribers relationship to patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**

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.

Insurance Authorization and Assignment:

I hereby authorize my attending physician to furnish to the insurance carriers listed above 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 collection agency.

SIGNATURE:____ **DATE:** ____________________

Privacy Practices 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) and MedStar Medical Group's Patient Information Letter.

SIGNATURE: ____ **DATE:** ____________________