

MedStar Medical Group – Dorsey Hall
9501 Old Annapolis Road, Suite 308
Ellicott City, MD 21042
Phone: 301-621-6570
Fax: 301-621-6589

PATIENT REGISTRATION and AUTHORIZATION FORM

Patient Information:

Name (Last): _____ (First): _____ (Middle): _____

Street: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Sex: Male Female

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

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: _____

Street: _____ Apt: _____

City: _____ State: _____

Zip Code: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Primary Insurance Information:

Plan Name: _____

Plan ID #: _____

Plan Group #: _____

Subscriber's name: _____

Subscriber's Date of Birth: _____

Subscriber's relationship to patient: Self Spouse Parent

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).

SIGNATURE: _____ DATE: _____