MedStar Physician Partners

MPP at MedStar Washington Hospital Center
106 Irving Street, N.W.
Suite 4200 North
Washington, D.C. 20010
Phone: 202-877-2200 Fax: 202-877-2208

REGISTRATION FORM

Guarantor Information – Person Responsible For Payment

Guarantor Name (Last)	(First)	(MI)	Sex	Date of Birth	Age	Race

Address	Address Line 2	City	State	Zip Code	Marital Status

Social Sec. #	Home Phone	Work Phone	Employed	Employer/School

Patient Information (IF THIS INFORMATION IS THE SAME AS ABOVE PLEASE LEAVE BLANK)

Patient's Name (Last)	(First)	(MI)	Sex	Date of Birth	Age	Race	Account #

Address	Address Line 2	City	State	Zip Code	Marital Status

Social Sec. #	Home Phone	Work Phone	Employed	Employer/School

Person to Notify In Case of Emergency

Emergency Contact Name	Relationship to Patient

Address	Address Line 2	City	State	Zip Code

Phone Number (HOME)	Phone Number (CELL)

Primary Insurance: _____ Policy # _____ Group # _____ Co-payment $_____

Subscriber's Name: _____ Subscriber's SS# _____ DOB: _____

Patient's Relationship to subscriber: _____

Secondary Insurance: _____ Policy #_____ Group # _____ Co-payment $_____

Subscriber's Name: _____ Subscriber's SS# _____ DOB: _____

Patient's Relationship to subscriber: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

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

PATIENT/GUARDIAN 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 the collection agency.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____