Welcome to MedStar Harbor Primary Care

Patient Information

Last name:	First:		M.I.:
Addresss:			
City:	Zip:	Sex:	Marital Status:
Employer:			
Cell Phone:	Home Phone:		
Date of Birth:	SSN:		
Gender:	Race:	Ethnicity:	
What is your preferred method of communication?			
What is your preferred language?			
Do you have a living will? YES NO	Do you have advanced directives? YES NO		
How did you hear about our practice? Check one. ☐ Family Member/Friend* ☐ Referred by MedStar Harbor Hosptial ☐ Insurance			
*Name of family member/friend who referred you: _____ (Just so that we may send them a thank you note!)			

Insurance Information

Insurance (card requested at time of service):		
Are you the policy holder? YES NO		
If not, who is the policy holder?	Relation? SPOUSE PARENT	
Address:		
Phone:	Date of Birth:	Employer:

Emergency Contact

Name:	Relation:
Phone Number:	

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:

MedStar Harbor Primary Care does not offer chronic pain management/treatment with narcotic prescriptions.

MedStar Harbor Hospital