



# PATIENT REGISTRATION FORM (please print clearly)

TODAY'S DATE		PATIENT'S NAME – FIRST		MIDDLE	LAST	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME ADDRESS – STREET				APT. #	CITY			STATE	ZIP
HOME PHONE		WORK PHONE		CELL PHONE			EMAIL ADDRESS		
DATE OF BIRTH		AGE	SOCIAL SECURITY NUMBER		OCCUPATION				
EMPLOYER		ADDRESS – STREET			CITY		STATE	ZIP	
SPOUSE OR PARENT NAME		SPOUSE OR PARENT EMPLOYER		ADDRESS			WORK PHONE		
IN CASE OF EMERGENCY NOTIFY		ADDRESS			HOME PHONE		WORK PHONE		
FINANCIALLY RESPONSIBLE PERSON <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				NAME (IF DIFFERENT THAN PATIENT)					
ADDRESS (IF DIFFERENT FROM PATIENT)					HOME PHONE		WORK PHONE		
NAME OF PREFERRED PHARMACY			LOCATION				PHONE NUMBER		
HOW WERE YOU REFERRED? <input type="checkbox"/> PRIMARY CARE DOCTOR <input type="checkbox"/> ER ANNE ARUNDEL HOSPITAL <input type="checkbox"/> OTHER ER <input type="checkbox"/> SELF <input type="checkbox"/> FRIEND <input type="checkbox"/> RELATIVE <input type="checkbox"/> WEB SEARCH <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COACH <input type="checkbox"/> OTHER (PLEASE PROVIDE WHOM) _____									

## HEALTH INSURANCE INFORMATION

IS INJURY <input type="checkbox"/> JOB RELATED <input type="checkbox"/> RESULT OF AUTO ACCIDENT <input type="checkbox"/> PERSONAL ACCIDENT INVOLVING LIABILITY									
HEALTH INSURANCE CO. NAME			INSURANCE CO. ADDRESS						
ID/POLICY NO.			GROUP NO.			EFFECTIVE DATE			
POLICYHOLDER		POLICYHOLDER'S RELATION TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			SOCIAL SECURITY NO.		DATE OF BIRTH		
INSURED'S EMPLOYER		ADDRESS					WORK PHONE		
SECONDARY INSURANCE COVERAGE			INSURANCE CO. ADDRESS						
ID/POLICY NO.			GROUP NO.			EFFECTIVE DATE			
POLICYHOLDER		POLICYHOLDER'S RELATION TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			SOCIAL SECURITY NO.		DATE OF BIRTH		
INSURED'S EMPLOYER		ADDRESS					WORK PHONE		

## PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I hereby authorize the release of any medical information necessary to process an insurance claim and do assign to the doctor all money to which I am entitled for medical and/or surgical expenses relative to this case. I understand that I am financially responsible to the doctor for all charges not covered by this assignment. I understand that payment for services are due at the time of service.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

INTEROFFICE USE ONLY

ACCT# _____	DOCTOR _____	RECEPTIONIST _____	DATE _____
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IS INJURY       JOB RELATED       RESULT OF AUTO ACCIDENT       PERSONAL ACCIDENT INVOLVING LIABILITY

IF INJURY IS RELATED TO ANY OF THE ABOVE, PLEASE COMPLETE APPROPRIATE SECTION, OTHERWISE READ AND SIGN LAST SECTION.

## FOR WORK RELATED INJURIES

EMPLOYER AT TIME OF ACCIDENT		DATE OF INJURY
ADDRESS		PHONE
WAS INJURY REPORTED TO SUPERVISOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF SUPERVISOR	
DESCRIPTION OF INJURY		
ATTORNEY'S NAME	PHONE	
ADDRESS		
WORKER'S COMPENSATION CARRIER		
ADDRESS	ADJUSTOR'S NAME	
CLAIM NUMBER	PHONE	

## FOR AUTO OR PERSONAL ACCIDENT (LIABILITY)

DATE OF ACCIDENT	LOCATION/DESCRIPTION OF ACCIDENT
YOUR AUTO INSURANCE CO.	
PIP CARRIER	INSURED
ADDRESS	ADJUSTOR'S NAME
CLAIM #	PHONE
ATTORNEY'S NAME	PHONE
ADDRESS	
OTHER INSURANCE CO.	INSURED
ADDRESS	ADJUSTOR'S NAME
CLAIM #	PHONE

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment at the time of service.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
Patient Signature or Guardian, if minor