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(301) 881-5888

PATIENT REGISTRATION FORM

We would like to take this opportunity to welcome you and to thank you for joining our medical practice. We appreciate your confidence and we will do everything possible to provide you with the finest medical care. Please fill out these forms completely: the better we communicate, the better we can care for you!

Name: _____ Social Security #: _____

Date of Birth: _____ Marital Status: _____ Male: _____ Female: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Spouse's Work Phone: (_____)_____

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INSURANCE INFORMATION: Do you have vision coverage with your insurance? _____
Do you need a referral for this visit from your primary care doctor? _____

Medicare#: _____ Primary _____ Secondary

Primary Insurance Co: _____

Address: _____

Policy #: _____ Group #: _____ Policy Owner: _____

Relation to patient (please circle one): Self Spouse Child Other: _____

****

Secondary Insurance Co: _____

Address: _____

Policy #: _____ Group #: _____ Policy Owner: _____

Relation to patient (please circle one): Self Spouse Child Other: _____

****

Medical Assistance #: _____ Color of card: _____

Local Medical Doctor: _____ Telephone #: (_____) _____

Address: _____

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Who referred you to this practice? _____

****

Your Employer: _____ Telephone #: (_____) _____

Address: _____

Your Occupation: _____

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RESPONSIBLE PARTY INFORMATION:

Relation to patient (please circle one): Self Spouse Parent Other: _____

Name: _____ Social Security #: _____

Date of Birth: _____ Marital Status: _____ Male:_____ Female: _____

Street Address: _____ Apt #: _____

City:_____ State: _____ Zip: _____

Mailing Address (if different): _____

Home Phone: (_____)_____ Work Phone: (_____) _____

Employer Name & Address:_____

****

WORKERS COMPENSATION

Date of Injury: _____ Cause of injury: _____

Bills Sent To: (Name & Address) _____

_____

Telephone #: _____ Verified By: _____

IF WORKERS COMPENSATION DOES NOT COVER THESE CHARGES, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE: _____

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AUTHORIZATION: I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITY. I AUTHORIZE MY DOCTOR TO PROVIDE MY INSURANCE COMPANY WITH ANY REQUESTED MEDICAL INFORMATION. I UNDERSTAND MY INSURANCE COMPANY DOES NOT GUARANTEE PAYMENT OF SERVICES.

Patient/Responsible Party signature: _____ Date: _____