

# PHYSICIAN ASSOCIATES

6000 EXECUTIVE BLVD #300  
 ROCKVILLE, MD 20852  
 301-468-8999

REGISTRATION FORM

Today's Date \_\_\_ / \_\_\_ / \_\_\_

PLEASE PRINT

PATIENT INFORMATION										
PATIENT NAME (LAST, FIRST, MIDDLE)							DATE OF BIRTH	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
STREET ADDRESS			APT#	CITY		STATE		ZIP CODE		
HOME PHONE		CELL PHONE		WORK PHONE		EMAIL ADDRESS				
OCCUPATION		EMPLOYER			RETIRED <input type="checkbox"/> YES <input type="checkbox"/> NO		STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO FULL TIME? _____			
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LIFE PARTNER		LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> CHINESE <input type="checkbox"/> FRENCH <input type="checkbox"/> KOREAN <input type="checkbox"/> SPANISH <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER _____			RACE <input type="checkbox"/> REFUSED TO REPORT <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> MORE THAN ONE RACE					

EMERGENCY CONTACT			
NAME		RELATIONSHIP	
ADDRESS		HOME PHONE	WORK PHONE

PREVIOUS OR REFERRING PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_

INSURANCE INFORMATION									
PRIMARY INSURANCE					SECONDARY INSURANCE				
INSURANCE COMPANY NAME					INSURANCE COMPANY NAME				
ID #		GROUP #			ID #		GROUP #		
SUBSCRIBER'S NAME			EMPLOYER		SUBSCRIBER'S NAME			EMPLOYER	
RELATIONSHIP TO PATIENT		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH ___ / ___ / ___		RELATIONSHIP TO PATIENT		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH ___ / ___ / ___	
NAME OF PERSON RESPONSIBLE FOR BILL					RELATIONSHIP TO PATIENT				
STREET ADDRESS				CITY		STATE		ZIP CODE	
HOME PHONE					WORK PHONE				

### Patient Authorization

I certify that the information that I have reported with regard to my insurance coverage is true and correct to the best of my knowledge. I authorize Physician Associates to apply for benefits on my behalf for covered services rendered. I release payment of all medical insurance benefits which are payable to me under the terms of my insurance policy or any third party payer, be made directly to Physician Associates. **I understand and agree that I am ultimately responsible for the balance on my account for any medical service rendered.** I further authorize the release of any necessary information, including medical information, needed for processing my insurance claim to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financial Administration). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above named provider for any services furnished me or physician/supplier. I authorize any holder of medical information about me to release to \_\_\_\_\_ (medigap carrier).

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_