PHYSICIAN ASSOCIATES

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

REGISTRATION FORM

Today's Date 19__ /19__ /19__

PLEASE PRINT

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST,MIDDLE)			DATE OF BIRTH	AGE	SEX
Jim Mole	443	Bethesda	___/___/___		○M ○F
STREET ADDRESS	APT#	CITY	STATE		ZIP CODE
1234 Main					

HOME PHONE	CELL PHONE	WORKPHONE	EMAIL ADDRESS

OCCUPATION	EMPLOYER	RETIRED ○YES ○NO	STUDENT ○YES ○NO FULLTIME?___

MARITAL STATUS	LANGUAGE	RACE
☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED ☐LIFE PARTNER	☐ENGLISH ☐CHINESE ☐FRENCH ☐KOREAN ☐SPANISH ☐VIETNAMESE ☐OTHER_____	☐REFUSED TO REPORT ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐BLACK OR AFRICAN AMERICAN ☐NATIVE HAWAIIAN ☐WHITE ☐OTHER PACIFIC ISLANDER ☐MORE THAN ONE RACE

EMERGENCY CONTACT

NAME	RELATIONSHIP	
Jane Doe		
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 ○M ○F	DATE OF BIRTH ___/___/___	RELATIONSHIP TO PATIENT	SEX ○M ○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** _____