Baltimore·Bel Air·Bowie·Foggy Bottom·Germantown·Greenbelt·Rockville·Shady Grove·Silver Spring·Towson·Westminster

(PLEASE PRINT CLEARLY)

Patient Information

Last Name:_____ First Name:_____ Middle Name:_____
Preferred Name/Nickname: _____ Gender: Male _____ Female _____
DOB: _____ Marital Status: _____ Social Security #: _____
Home #: _____ Cell #: _____ Work #:_____
Home Address: _____City: _____State: __ Zip Code: _____
Mailing Address (if different from Home): _____
City: _____ State: _____ Zip Code: _____
Which address is linked to insurance (Circle): HOME MAILING

Patient Portal Access

Patient's/Parent of Patient's E-mail Address for access to our Patient Portal (must be a separate E-mail for each family member): _____

Emergency Information

Emergency Contact Name: _____ Relationship: _____
Cell #: _____ Home #: _____ Work #: _____

How did you hear about us? (Circle)
Referring Physician/ Friend/ Family Member/ Website/ Walk-in/ Insurance Website

Pharmacy Information

Pharmacy: _____ Address: _____
Phone #: _____ Fax #:_____

Primary Care Information

Primary Care Physician: _____ Address: _____
Phone#:_____ Fax#:_____
If Referring Physician is different than your Primary Care Doctor:
Referring Physician: _____ Address: _____
Phone#:_____ Fax#:_____

Race(s): (Circle) Caucasian African American Asian American Indian Other _____
Ethnicity: (Circle) Hispanic Non-Hispanic

Parental Information (for minors only)

Mother's Name: _____ DOB: _____ Social Security #: _____
Address:_____ City: _____State: ____ Zip Code: _____
Home #:_____Cell #: _____Work #: _____

Father's Name: _____ DOB: _____ Social Security #: _____
Address:_____ City: _____State: ____ Zip Code: _____
Home #:_____Cell #: _____Work #: _____

Insurance Information

Primary Insurance: _____
Policy Holder: _____ DOB:_____ Social Security #:_____
Referral Required? (Circle) YES NO
** If so, please make sure we have it on file. Your benefits may be reduced if we do not.
Identification #: _____ Group #: _____
Medicaid # (if applicable):_____
Specialist Copay Amount: _____

Secondary Insurance: _____
Policy Holder: _____ DOB:_____ Social Security #:_____
Referral Required? (Circle) YES NO
** If so, please make sure we have it on file. Your benefits may be reduced if we do not.
Identification #: _____ Group #: _____
Medicaid # (if applicable):_____

*******Important*******

***If you are a Legal Guardian of the patient you must have documentation with you.**
***If you are a friend or relative bringing the patient you must have written permission from the parent to allow you to consent to medical treatment.**

I _____ (print name) certify that the above information is correct to the best of my ability.

X_____ Relationship:_____ Date:_____