

Mid-Maryland Musculoskeletal Institute

Patient Registration Form

Welcome to our office. Please fill out all the information completely. **PLEASE PRINT or TYPE.** All information will be kept strictly confidential.

Patient's Name		Sex M F	Birth Date ____/____/____ Age _____	Patient's Social Security #		
Home Address		City	State	Zip	Home Phone	Cell Phone
Patient's Employer		Business Phone		Occupation	Marital Status Single [] Married [] Widowed [] Divorced []	
Employer Address						
Person financially responsible for this account		Self Spouse Parent	Responsible Party's Birthdate ____/____/____		Responsible Party's Social Security #	
Responsible Party's Employer						
Responsible Party Address				Home Phone	Work Phone	
Street		City	State	Zip		
Name of Spouse/Nearest Relative		Relationship to patient	Home Phone	Business Phone		
Person to contact in case of emergency		Relationship to patient	Phone			
Reason for Visit		Primary Care Physician (include address and phone)				
Worker's Compensation? Yes [] No [] Motor Vehicle? Yes [] No []		Date of Injury / Onset				
If Yes - put W/C or MVA carrier below						
Primary Insurance Company		Address		Is insurance through your employer? Y N Spouse's employer? Y N		
Subscriber Name		Social Security #	Subscriber Birthdate	Policy #	Group #	
Secondary Insurance Company		Address				
Subscriber Name		Social Security #	Subscriber Birthdate	Policy #	Group #	
<u>Medicare Lifetime Signature on File:</u>						
I, the undersigned, consent to medical evaluation and treatment by Mid-Maryland Musculoskeletal Institute. I request that payment of authorized Medicare benefits be made on my behalf to Mid-Maryland Musculoskeletal Institute for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Center For Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.						
_____			_____			
Patient Signature			Date			
Private Insurance Authorization for Assignment of Benefits/Information Release:						
I, the undersigned, consent to medical evaluation and treatment by Mid-Maryland Musculoskeletal Institute. I authorize payment of medical benefits to Mid-Maryland Musculoskeletal Institute for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or its agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.						
_____			_____			
Patient, Parent or Guardian Signature (if child is under 18 years old)			Date			