

PATIENT INFORMATION SHEET

PATIENT INFORMATION	LEGAL NAME <i>PLEASE PRINT</i> LAST FIRST MIDDLE			<input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		
	STREET ADDRESS			CITY	STATE	ZIP	
	HOME PHONE		WORK PHONE INCL. EXTENSION		DATE OF BIRTH		S.S.#
	EMPLOYER'S ADDRESS			CITY	STATE	ZIP	
INSURANCE INFORMATION	PRIMARY INSURANCE COMPANY						
	INSURANCE CARRIER'S COMPLETE ADDRESS			CITY	STATE	ZIP	
	NAME OF POLICYHOLDER			RELATIONSHIP TO PATIENT	DATE OF BIRTH		S.S.#
	POLICYHOLDER'S EMPLOYER			POLICY #		GROUP #	
	SECONDARY INSURANCE COMPANY						
	INSURANCE CARRIER'S COMPLETE ADDRESS			CITY	STATE	ZIP	
	NAME OF POLICYHOLDER			RELATIONSHIP TO PATIENT	DATE OF BIRTH		S.S.#
	POLICYHOLDER'S EMPLOYER			POLICY #		GROUP #	
RESPONSIBLE PARTY	WHO IS RESPONSIBLE FOR PAYING THE BILL? <input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER (LIST BELOW)						
	NAME						
	STREET ADDRESS			CITY	STATE	ZIP	
	PHONE		RELATIONSHIP TO PATIENT		S.S.#		
	SIGNATURE OF RESPONSIBLE PARTY						
	IN CASE OF AN EMERGENCY CONTACT			RELATIONSHIP	DAYTIME PHONE	EVENING PHONE	

ASSIGNMENT & RELEASE

I, _____ certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to process any claim to Medicare, Social Security Administration and Health Care Financing Administration, and/or any other agents needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I hereby authorize any payments submitted to be made directly to Maryland Primary Care Physicians (or in case of Medicare B, benefits to the party who accepts assignment). Authorization may be revoked by me at any time in writing. I understand I am financially responsible for any balance deemed "patient" responsibility.

SIGNATURE OF SUBSCRIBER, BENEFICIARY OR RESPONSIBLE PARTY

DATE

My signature above also acknowledges receipt of MPCP/PMG's Notice of Privacy Practices, Version 1.0, effective 4/14/03. _____ Initials