8186 Lark Brown Road Elkridge MD 21075
10981 Johns Hopkins Road Laurel MD 20723
(410) 730-3399

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION (Please Print)

LAST NAME:________________________________ FIRST NAME: ________________________________ MI: _________

DATE OF BIRTH: _____________________ SEX: __________ RACE: _________________________

SOCIAL SECURITY: ________________________________ ETHNICITY: ____________________________________

ADDRESS 1: ____ ADDRESS 2: _________________________________

CITY: _______________________________________ STATE: ____________________ ZIP CODE: ________________

LANGUAGE: ___________________________________ LANGUAGE COUNTRY: ________________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

Check if applicable: ☐ PREGNANT ☐ NURSING

Whom may we thank for referring you to our practice? ____

CONTACT INFORMATION

HOME PHONE: ___________________________ WORK PHONE ___________________________ EXT: ________

CELL PHONE: ___________________________ EMAIL: ____

EMERGENCY CONTACT INFORMATION (whom may we contact in case of an emergency)

FIRST NAME: ______________________________________ LAST NAME: ______________________________________

HOME PHONE: ____________________________________ CELL PHONE: _____________________________________

RELATIONSHIP TO PATIENT: ____

ADDRESS: ____

CITY: ____________________________________ STATE: ____________________ ZIP CODE: ____________________

FAMILY MEMBERS IN THE PRACTICE

______________________________________ (name) ______________________________________ (relationship to patient)

______________________________________ (name) ______________________________________ (relationship to patient)

______________________________________ (name) ______________________________________ (relationship to patient)

______________________________________ (name) ______________________________________ (relationship to patient)

PRIMARY CARE/OTHER PHYSICIAN

PHYSICIAN NAME: ______________________________________ PRACTICE NAME: ______________________________________

ADDRESS: _________________________________ CITY: _______________________ STATE: __________ ZIP CODE: ___________

PHARMACY NAME: ______________________________________ PHARMACY PHONE: _____________________________

PHARMACY LOCATION: ____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian: ____ **Date:**____________________

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INSURANCE INFORMATION

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF VISIT

PRIMARY INSURANCE

INSURANCE COMPANY: ____ CO-PAY: ___________________

GROUP #: _______________________________________ SUBSCRIBER ID#: ________________________________

INSURED FIRST NAME: _________________________ INSURED LAST NAME: _________________________ MI: ________

SOCIAL SECURITY #: _______________________ DATE OF BIRTH: ____________ RELATION TO PATIENT: _________________

ADDRESS: _____________________________ CITY: ________________ STATE: __________ ZIP CODE: ______________

PHONE #: _________________________ (EXT: _________)

INSURED EMPLOYED BY: ___________________________________ BUSINESS ADDRESS: ______________________________

CITY: _________________________________ STATE: _______________ ZIP CODE: ____________________

BUSINESS PHONE #: ___________________________

ADVANCED DIRECTIVES? ☐ YES ☐ NO WHERE IS IT FILED? ________________________ (What medical facility?)

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: ____ CO-PAY: ___________________

GROUP #: _______________________________________ SUBSCRIBER #: ________________________________

INSURED FIRST NAME: _____________________________ INSURED LAST NAME: ____________________________

SOCIAL SECURITY #: _______________________ DOB: ________________ RELATION TO PATIENT: ____________________

ADDRESS: ___________________________________ CITY: _________________ STATE: _________ ZIP CODE: ____________

PHONE #: _________________________ (EXT: _________)

INSURED EMPLOYED BY: ____

ADDRESS: ______________________________ CITY: ____________________ STATE: __________ ZIP CODE: ____________

BUSINESS PHONE: ___________________________

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED? ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____________________________________ BUSINESS NAME: _________________________________

BUSINESS PHONE: ____________________________

DRIVER LICENSE #: _______________________________________ STATE ISSUED: _______________________

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY? ____________________

IS THIS A MOTOR VECHICLE ACCIDENT? ☐ YES ☐ NO

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Signature of Insured/Guardian: ____ **Date:** __________________

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Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Centennial Medical Group and/or FirstCall Urgent Care in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practice for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from your front desk staff.

You retain the right to request that we further restrict how your protected health information is release or used to carry out treatment, payment, or health care operations. Our practice is not requested to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

I agree and consent to Centennial Medical Group and/or FirstCall Urgent Care releasing information to me in the following manners:

VIA MAIL — PLEASE INITIAL

- ☐ OK TO MAIL TO HOME ADDRESS __________
- ☐ OK TO MAIL TO WORK ADDRESS __________

VIA HOME TELEPHONE

- ☐ OK TO LEAVE DETAILED MESSAGE __________
- ☐ LEAVE CALL BACK NUMBER ONLY __________

VIA WORK TELEPHONE

- ☐ OK TO LEAVE DETAILED MESSAGE __________
- ☐ LEAVE CALL BACK NUMBER ONLY __________

VIA FAX

OK TO FAX TO: ________________________________

By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian: ____ Date:_________________