CENTENNIAL MEDICAL GROUP
8186 Lark Brown Road Elkridge MD 21075
10981 Johns Hopkins Road Laurel MD 20723
(410) 730-3399
FirstCall URGENT CARE
DOCTORS ALWAYS ON CALL

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION (Please Print)

LAST NAME:_____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SEX: _____ RACE: _____

SOCIAL SECURITY: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ MD: _____ 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:**_____