



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: _____ 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 VEHICLE ACCIDENT? YES NO

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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 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 FirstCall Urgent Care releasing information to me in the following manners:

VIA MAIL	PLEASE INITIAL
<input type="checkbox"/> OK TO MAIL TO HOME ADDRESS	_____
<input type="checkbox"/> OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGE	_____
<input type="checkbox"/> LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGE	_____
<input type="checkbox"/> LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
<input type="checkbox"/> OK TO FAX TO: _____	

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

Signature of Insured/Guardian: _____ **Date:** _____