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 / **Employer Address**	**Business Phone**	**Occupation**	**Marital Status** Single ○ Married ○ Widowed ○ Divorced ○
Person financially responsible for this account / **Responsible Party's Employer**	Self ○ Spouse ○ Parent ○	**Responsible Party's Birthdate** __/__/__	**Responsible Party's Social Security #**
Responsible Party Address Street City State Zip		**Home Phone**	**Work Phone**
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 ○ **If Yes - put W/C or MVA carrier below**	**Date of Injury / Onset**		
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 #

Medicare Lifetime Signature on File:

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