PATIENT REGISTRATION FORM

MEDICAL ACCESS / GPCA 12321 Middlebrook Road • Germantown, MD 20874 Tel: 301-428-1070 Fax: 301-428-3192

Type of Car: ______________________

Color of Car: ______________________

Email (required): ______________________

Cell: ______________________ Android___iPhone___

Patient Registration (Please Print Clearly)

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Prof. ☐ Other .... ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Other ....

Patient's Name (Last, First, Middle)					Home Phone
Patient's Home Address	Apt No.	City		State	Zip
Date Of Birth	Social Security Number	Age	Sex	Work Phone	
Spouse's Name (Last, First, Middle)		Spouse's Cell/Other Phone		Date Of Birth	
Current Primary Care Physician ☐ Yes ☐ No	If Yes, Print Name		Who Is Your Referring Physician?		
Person To Notify In Case Of Emergency	Address	City	State	Zip	Cell Phone
Relationship To Patient					Work/Other Phone

PERSON FINANCIALLY RESPONSIBLE

Person Financially Responsible if not above ______________________

Relationship: ______________ Birthdate: ______________ Soc. Sec. #: ______________

PRIMARY INSURANCE

Insurance Company Name			
Identification Number	Service Or Enrollment No. Or Group No.		Effective Date Of Contract
Subscriber's Name	Subscriber's Birthdate	Subscriber's Relationship To Patient	Subscriber's Employer

SECONDARY INSURANCE

Insurance Company Name			
Identification Number	Service Or Enrollment No. Or Group No.		Effective Date Of Contract
Subscriber's Name	Subscriber's Birthdate	Subscriber's Relationship To Patient	Subscriber's Employer

SOCIAL HISTORY

Occupation	Is your job: ☐ Heavy ☐ Moderate ☐ Light	History of drug abuse or drug addictions ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Current packs per day ________ How many years ________	Alcohol Use ☐ Never ☐ Occasionally ☐ Daily	History of heavy alcohol use ☐ Yes ☐ No

Home environment: ______________ Private home ______________ Assisted Living ______________ Other (describe)

OVER

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MEDICAL HISTORY

PAST MEDICAL PROBLEMS	PRESCRIPTION MEDICATIONS
PAST HOSPITALIZATION & SURGERIES	**ALLERGIES & REACTIONS**

Please select YES or NO

Have you had a fever in the last 48 hours?	☐ Yes	☐ No
Do you have a cough/shortness of breath?	☐ Yes	☐ No
Are you experiencing abdominal pain, vomiting, or diarrhea?	☐ Yes	☐ No
Have you had close contact with or cared for someone diagnosed with COVID-19?	☐ Yes	☐ No
Have you been diagnosed with COVID-19?	☐ Yes	☐ No
Have you or anyone in your family traveled outside of the country in the last 21 days?	☐ Yes	☐ No

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

We will communicate appointments, reminders, lab results and messages through e-mail, text and portal. If you do not wish to receive these please send us an e-mail at *info@medicalaccessmd.com* or give it to us in writing. Per HIPAA regulations, please list who you authorize to discuss your medical information with:

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

PLEASE CIRCLE:

RACE:	ETHNICITY:	LANGUAGE SPOKEN:	NATIONALITY:
American Indian/Alaskan; Asian; Black/African-American; Hispanic; Native Hawaiian or another Pacific Island; White	Hispanic or Latino; Non-Hispanic or Latino	English; French; German; Hindi; Japanese/Chinese; Portuguese; Russian; Spanish; Other: ______________	African-American; American; Arabian; Asian-Indian; British; Chinese; Eastern European; French; German; Hispanic; Italian; Japanese; Korean; Mexican; Polish; Puerto Rican; Russian; Scot/Irish; Spanish: Other: ____________

FINANCIAL STATEMENT

I authorize Medical Access/Manbir Takhar PC to apply for benefits on my behalf for the services rendered by the physician and staff. I request payments from my insurance, Medicare or responsible party be made to the entities herein. I certify that all of the information I have provided is correct to the best of my knowledge.

I agree to allow Medical Access/Manbir Takhar PC to charge my credit card on file for any amount not covered by insurance for the services related to my appointments and services provided by the two entities named herein. I will receive a bill and receipt for any charges made to my account. I understand that my credit card will be stored on Elavon, Inc a secure credit card processer affiliated with U.S. Bank that partners with entities named herein.

I agree to be financially responsible for any balance due. If my account becomes assigned to a collection agency, I agree to pay a 30% collection agency fee, court cost, and attorney fees.

I authorize the release of any medical information for this claim or related claim. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Patient/Guardian/Beneficiary Signature: ______________________ **Date:** ______________