Maryland Endocrine, P.A.

Account #: _____

Date: _____

PATIENT INFORMATION

Name: _____
Last *First* *MI*

Address: _____

Apt: _____ PO Box _____

City: _____ State ____ Zip _____

Social Security # (optional): _____

Marital Status: _____ Sex: (M/F/TG) _____

Primary Phone #: Circle (H) (C) (W) _____

Secondary Phone #: Circle (H) (C) (W) _____

Tertiary Phone #: Circle (H) (C) (W) _____

E-Mail Address: _____

Would you like to be web enabled for the patient portal? (Y/N) _____

Employed (Y/N) _____ Student (PT/FT) _____

Employer: _____

Emergency Contact person: _____

Relationship: _____ Number: _____

* Date of Birth: _____

* Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Black or African American
- ☐ White
- ☐ Other race.
- ☐ Other Pacific Islander
- ☐ Unreported/refused to report

* Ethnicity:
- ☐ Hispanic or Latin
- ☐ Non Hispanic or Latin
- ☐ Refused to report

* Preferred Language:
- ☐ English
- ☐ Indian (Includes Hindi and Tamil)
- ☐ Russian
- ☐ Spanish
- ☐ Other

Okay to leave message:
(Y/N) _____

Primary Care MD: _____ Phone Number: _____

Specialist MD: _____ Phone Number: _____

Specialist MD: _____ Phone Number: _____

PHARMACIES:

Local Pharmacy Name: _____ Number: _____

Local Pharmacy Location: _____

Mail Order Pharmacy Name: _____ Number: _____

TURN OVER AND COMPLETE THE OTHER SIDE AND SIGN PLEASE

Name: _____

DEMOGRAPHIC FORM PAGE II

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

Tertiary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I understand that physician phone calls are telehealth visits and that on line patient portal messages requiring physician input are billable services.

I authorize Maryland Endocrine, P.A. to apply for benefits on my behalf for covered services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. (Or in the case of Medical Part B benefits to Social Security Administration and Health Care Financing Administration).

I authorize payment of medical insurance benefits which are payable to me under the terms of my insurance to be paid directly to Maryland Endocrine, P.A. for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

This authorization may be revoked by either me or my insurance carrier at any time in writing. I understand and agree that I am financially responsible for charges not paid by my insurance company.

_____ Date: _____

Signature of Patient, Insured or Beneficiary

I allow MARYLAND ENDOCRINE, P.A. to release any information relevant to my care to:

1) _____ Relationship: _____

2) _____ Relationship: _____

I the undersigned acknowledge everything on this form is correct to the best of my knowledge.

_____ Date: _____

Signature of Patient/Guardianship