UNIVERSITY PHYSICIANS
PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME — LAST — TITLE — FIRST — M I | DATE

SOCIAL SECURITY # | SEX ☐ MALE ☐ FEMALE | RACE | DOB

PLACE OF BIRTH — CITY — STATE — COUNTRY

HOME ADDRESS — STREET — CITY — STATE — ZIP CODE

HOME PHONE ( ) | MOTHER'S MAIDEN NAME | FATHER'S NAME

EMPLOYER | ☐ UMMS ☐ UPI ☐ MONTEBELLO ☐ CAMPUS ☐ KERNAN ☐ OTHER

EMPLOYER ADDRESS — STREET — CITY — STATE — ZIP CODE

WORK PHONE ( ) | OCCUPATION

PHYSICIAN YOU ARE SEEING TODAY.

WHO REFERRED YOU? ☐ AGENCY ☐ HMO / PPO ☐ FAMILY / FRIEND ☐ SELF ☐ HOSPITAL ☐ MEDIA / YELLOW PAGES | REFERRING PHYSICIAN NAME

REFERRING PHYSICIAN ADDRESS | REFERRING PHYSICIAN PHONE NUMBER ( )

IN CASE OF EMERGENCY CONTACT — NAME | EMERGENCY PHONE NUMBER ( )

AUTOMOBILE ACCIDENT INFORMATION

IS THIS VISIT THE RESULT OF AN AUTO ACCIDENT? ☐ YES ☐ NO | DATE OF ACCIDENT/INJURY | TYPE OF INJURY

INSURED'S NAME | INSURANCE COMPANY | PHONE NUMBER ( )

INSURANCE COMPANY ADDRESS — STREET — CITY — STATE — ZIP CODE

RESPONSIBLE PARTY

IF PATIENT AND GUARANTOR ARE THE SAME PERSON DO NOT FILL OUT SHADED AREA BELOW

NAME OF PERSON RESPONSIBLE FOR BILL | SOCIAL SECURITY NUMBER | D.O.B. | PHONE NUMBER ( )

GUARANTOR ADDRESS — STREET — CITY — STATE — ZIP CODE

GUARANTOR EMPLOYER | EMPLOYER PHONE NUMBER ( )

GUARANTOR EMPLOYER ADDRESS — STREET — CITY — STATE — ZIP CODE

INSURANCE COMPANY — PRIMARY

MEDICARE PATIENTS: ARE BENEFITS THROUGH AN HMO ☐ YES ☐ NO

NAME | POLICY NUMBER

GROUP NAME | GROUP NUMBER | EFF DATE

ADDRESS — STREET — CITY — STATE — ZIP CODE

PHONE NUMBER ( ) | MAJOR MEDICAL COVERAGE ☐ YES ☐ NO

CARDHOLDER'S NAME | DOB | SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT

INSURANCE COMPANY — SECONDARY

NAME | POLICY NUMBER

GROUP NAME | GROUP NUMBER | EFF DATE

ADDRESS — STREET — CITY — STATE — ZIP CODE

PHONE NUMBER ( ) | MAJOR MEDICAL COVERAGE ☐ YES ☐ NO

CARDHOLDER'S NAME | DOB | SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT

PLEASE READ AND SIGN THE BACK OF THIS FORM

THANK YOU!

▼ FOR OFFICE USE ONLY ▼

UNIVERSITY PHYSICIANS PATIENT REGISTRATION FORM

AUTHORIZATION & ASSIGNMENTS - Please Read Before Signing

MEDICARE: I request that payment of Authorized Medicare benefits be made on my behalf for any services furnished to me by

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

BLUE SHIELD OF MARYLAND: I understand the charge of a non - participating physician may exceed the Blue Shield of Maryland, Inc. payment, and if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim.

OTHER INSURANCE: I authorize and assign payment directly to the physician / physicians involved in my treatment or my child's treatment and authorize release of medical information necessary to process this claim. I further understand that I am financially responsible for charges not covered by my insurance.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN

SIGN HERE ______________________ (SEAL) DATE ______________________

RELATIONSHIP
TO PATIENT (IF OTHER THAN PATIENT) ______________________

MANAGED CARE FINANCIAL GUARANTEE: I understand that without an authorization or referral from my HMO/IPA/PPO, as indicated below, I am financially responsible for charges incurred for services rendered by ______________________ on ____/____/____.

I also understand that I am responsible for charges incurred for services considered to be non-covered by my HMO/IPA/PPO.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN

SIGN HERE ______________________ (SEAL) DATE ______________________

RELATIONSHIP
TO PATIENT (IF OTHER THAN PATIENT) ______________________