



Appointment date: _____

Appointment time: _____

(Office Use Only)

Quarterfield Center, 808 Landmark Drive, Suite 120, Glen Burnie, MD 21061 Phone: (410) 768-7979 Fax: (410) 768-7983

Patient Registration Form

Name: _____
First Middle Last

Home Phone: _____

Address: _____
Street

Work Phone: _____

City State Zip

Cell Phone: _____

Email _____

Sex: Male Female Date of Birth: _____ Age: _____ SS# _____

Marital Status: S M D W Patient's Employer: _____ Occupation: _____

Full-time Student: Yes No Prior employer/occupation if retired _____

Spouse (or parent if minor): _____ How did you hear about us? _____

Name of emergency contact person: _____ Phone: _____

Name of referring physician: _____ Phone: _____

History of melanoma: Yourself? Family member? Relationship: _____

Are you on a prescription plan? _____ Pharmacy Name: _____ Phone _____

Allergies to medications: _____

Current medications (including aspirin and herbal supplements): _____

Note: Please present your current insurance ID cards for photocopying.

Primary Insurance Company: _____

Insurance ID#: _____ Group# _____

Policyholder's Name: _____ Relationship _____

If the patient is not the policyholder, please fill out below:

Policyholder's address: _____ Phone: _____

Policyholder's sex: Male Female Birthdate: _____ SS# _____

Policyholder's employer: _____ Work phone: _____

Secondary Insurance Company: _____

Insurance ID#: _____ Group# _____

Policyholder's Name: _____ Relationship _____

If the patient is not the policyholder, please fill out below:

Policyholder's address: _____ Phone: _____

Policyholder's sex: Male Female Birthdate: _____ SS# _____

Policyholder's employer: _____ Work phone: _____

Note: Please complete the other side of this form.



We have listed the policies of the office regarding medical treatment authorization, billing, and general office procedures. In order to comply with Federal regulations, please read, initial, and sign where indicated so that we can treat you.

Authorization to treat and bill for services

- _____
- Initial**
- I authorize Dr. Brown and his staff to treat my medical condition(s) and to bill my insurance company for services rendered.
 - I authorize Dr. Brown and his staff to release my medical information to other physicians if necessary to ensure that I receive quality medical care.
 - I authorize Dr. Brown and his staff to release my medical information to my insurance company or pharmacy if requested in order to obtain payment for services and/or medications.

Authorization to treat patients under the age of 18

- I authorize Dr. Brown and his staff to treat my minor child in my absence for this visit and for all future visits. I understand that I may call and speak to the doctor directly if I have questions regarding the treatment and care of my minor child.

Signature of parent/guardian

Relationship to patient

Date

Financial and Billing Policy

- _____
- Initial**
- I authorize Dr. Brown and his staff to bill and seek payment from my insurance company for services rendered to me.
 - I understand that I am responsible for payment of co-pay, co-insurance, and/or deductible amounts at the time of service.
 - I understand that I am responsible for my bill if my insurance does not cover the charges for any reason.
 - I understand that I am responsible for obtaining the necessary referrals (if required) from my primary care physician for services. If I do not obtain the necessary referrals I must either reschedule my appointment or pay for the services at the reduced benefit level as stated by my insurance plan.
 - I understand that any balances due after insurance are my responsibility and that balances due to Dr. Brown may be subject to a billing fee or have interest applied if my balance is not paid within 30 days.
 - I understand that there is a \$35.00 fee for returned checks. Payment for returned checks must be made by credit card, money order or cash within 30 days. Returned checks that are not paid after 30 days may be referred to a collection agency and collected to the fullest extent allowed by Maryland law.
 - I understand that if my account is referred to a collection agency for non payment, I will be responsible for the total amount of my bill plus collection/attorney fees.

General Office Policy

- _____
- Initial**
- I understand that there may be a \$34.00 fee assessed for missed appointments or appointments cancelled without 24 hours notice.
 - I understand that prescriptions refills will not be authorized unless I have been seen by the doctor within the past six months.
 - I have read, understand and have been offered a copy of the patient privacy policy as mandated by the Federal Government HIPAA regulations (privacy act).

Signature of patient

Date

Signature of parent/guardian

Relationship to patient