



# Sandy Spring After Hours Pediatrics

2911 Olney Sandy Spring Road, Suite C, Olney Maryland 20832 • 301 260-7777 • Fax 301 570-5710

## Patient Registration Form

### PATIENT DATA

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET APT# CITY/STATE ZIP CODE

Home Phone: \_\_\_\_\_ Gender:  M  F Birthdate: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear of this practice?  PCP  Family/Friend  Direct mail  Flyer  Driving by  Other: \_\_\_\_\_

### EMERGENCY CONTACT

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### RESPONSIBLE PARTY

Responsible Party's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET APT# CITY/STATE ZIP CODE

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Rel to Patient: \_\_\_\_\_

Gender:  M  F Birthdate: \_\_\_\_\_ Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_ Expiration: \_\_\_\_\_ *A copy is required.*

### INSURANCE INFORMATION

**Primary** Insurance Company Name: \_\_\_\_\_

Subscriber's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Gender:  M  F Birthdate: \_\_\_\_\_ Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_

ID/Membership/Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employment Status: \_\_\_\_\_

**Secondary** Insurance Company Name: \_\_\_\_\_

Subscriber's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

### PLEASE READ AND SIGN

The above information is true to the best of my knowledge. I understand that full payment is required at the time services are rendered and that I am financially responsible for payment of all professional fees regardless of insurance carrier. Professional fees include charges for the office visit and any in-house laboratory testing. I authorize SSAHP to bill my insurance for any send-out laboratory tests and give SSAHP consent to release any information required to process those claims.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP

### HIPPA ACKNOWLEDGEMENT

By signing this form, you acknowledge that Sandy Spring After Hours Pediatrics has provided you access to a copy of its Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us. [If you are unable, who is authorized to receive health-related information on your behalf? \_\_\_\_\_ ]

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

### FOR OFFICE USE

\_\_\_\_\_  
STAFF SIGNATURE : I have reviewed this form for completeness.