

# PATIENT REGISTRATION

DATE \_\_\_\_\_

NAME		WHAT WOULD YOU PREFER TO BE CALLED?	DATE OF BIRTH	AGE
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		SOC. SEC. NO	
REFERRED BY	<input type="checkbox"/> PATIENT OF DR OLDHAM <input type="checkbox"/> INTERNET <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> DOCTOR <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER _____		PRIMARY CARE PHYSICIAN	
REASON FOR CONSULTATION	ALLERGIES	DO YOU SMOKE?	HAVE YOU EVER SMOKED?	
ADDRESS	CITY	STATE	ZIP	
HOME PHONE	CELL PHONE	BUSINESS PHONE		
OCCUPATION	EMPLOYER	E-MAIL ADDRESS		
EMERGENCY CONTACT	<input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER _____		PHONE	
OCCUPATION	EMPLOYER			
PRIMARY HEALTH INSURANCE CO.	I.D. OR POLICY NO.		GROUP NO.	
ADDRESS	CITY	STATE	ZIP	PHONE
SUBSCRIBER'S NAME	BIRTH DATE	EMPLOYER		
SECONDARY HEALTH INSURANCE CO.	I.D. OR POLICY NO.		GROUP NO.	
ADDRESS	CITY	STATE	ZIP	PHONE
SUBSCRIBER'S NAME	BIRTH DATE	EMPLOYER		

I request that payment of authorized insurance carrier benefits be made on my behalf to Roger J. Oldham, M.D. and/or Bethesda Surgery Center for any services furnished to me by that physician or facility. I authorize the release of any medical information to my insurance carriers for the purpose of determining benefits for medical services. I agree to provide all referrals as required by my insurance carrier(s), and I agree to pay all co-pays at the time of service in accordance with the contracted insurance carrier agreements. I acknowledge I am financially responsible for medical services provided by Dr. Oldham and/or Bethesda Surgery Center even if I do not have medical insurance benefits. If I have medical insurance coverage effective at the time services were rendered, I will take responsibility for fees I owe as determined by my insurance carrier. I will pay these fees in full within 120 days of the date of service unless other arrangements have been made in writing with the billing or office manager. An interest fee of 1.5% may be charged per month on outstanding balances. I agree to pay collection costs, court costs and attorney fees if they are incurred.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_