

13035 BALTIMORE AVENUE
 Laurel, Maryland 20707
 (301) 497-0401
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 www.laurelmedicine.com

NEW PATIENT INFORMATION

PATIENT'S NAME	MARTIAL STATUS					SEX		DOB	S.S. #	AGE
	S	M	W	D	SEP	M	F			
STREET ADDRESS	CITY AND STATE					ZIP CODE		TELEPHONE #1 (HOME)		
PATIENT'S EMPLOYER	OCCUPATION					HOW LONG EMPLOYED?		TELEPHONE #2 (CELLULAR)		
EMPLOYER'S STREET ADDRESS	CITY AND STATE					ZIP CODE				
DRUG ALLERGIES, IF ANY							E-MAIL ADDRESS			
SPOUSE OR PARENT'S NAME	DOB					S.S. #		AGE		
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION					HOW LONG EMPLOYED?		BUSINESS TELE PHONE #		
EMPLOYER'S STREET ADDRESS	CITY AND STATE					ZIP CODE				
DO YOU HAVE A LIVING WILL?							DO YOU USE ILLEGAL DRUGS? IF SO, EXPLAIN.			
HOW DID YOU HEAR ABOUT US? (ie: NEWSPAPER, POST CARD, REFERRAL OR INSURANCE CARRIER WEBSITE)										

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		
INSURANCE CARRIER (PRIMARY)	ID #	GROUP #
INSURANCE CARRIER (SECONDARY)	ID #	GROUP #
MEDICARE ID #	RAILROAD RETIREMENT ID #	

INSURANCE AUTHORIZATION AND ASSIGNMENT

- I authorize use of this form on all my insurance submissions.
- I authorize disclosure of protected health information for treatment, payment and healthcare operation.
- I authorize release of information to all my Insurance Companies.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from the Insurance Companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I acknowledge that I have received Notice of Privacy Practice Information.

Print Name: _____

Date: _____