GI Associates of Maryland

Patient Registration

PLEASE PRINT CLEARLY –COMPLETE ALL AREAS

Last Name	First Name	Middle Initial	Date of Birth	Age

Home Address	Apt #	City	State	Zip

Social Security Number	Sex	Marital Status	Home Phone Number	Cell Phone Number
		❒S ❒M ❒D ❒W	( )	( )

Employer (or previous employer, if retired)	❒Self ❒Military ❒Retired ❒P/T ❒F/T	Preferred Contact Method	Work Phone Number
		Home ❒ Cell ❒ Work ❒	( )

Employer Address	City	State	Zip

Primary Care/Referring Physician Name	How did you hear about us

Email Address *(Patient)*	Email Address *(other responsible person)*

Responsible Party Information *(Person Responsible for Bill)* ☐***Same as patient*** *(check box)*

Name *Last* *First* *Middle Initial*	Date of Birth	Social Security Number	Sex

Relationship to Patient	Home Phone Number	Work Phone Number	Cell Phone Number
	( )	( )	

Home Address	Apt #	City	State	Zip

Primary Insurance Information:

Name of Insurance Company	Effective Date:

Insurance Company Address	City	State	Zip

Group Number	Policy Number	Subscriber Information *(if other, please state relationship and complete following information)* ❒Same as patient ❒Same as responsible party ❒Other:_____

Subscriber's Name *Last* *First* *Middle Initial*	Date of Birth	Social Security Number	Sex

Employer	Home Phone Number	Work Phone Number
	( )	( )

Secondary Insurance Information:

Name of Insurance Company	Copay Amount	Effective Date
	$	

Insurance Address	City	State	Zip

Group Number	Policy Number	Subscriber Information *(if other, please state relationship and complete following information)* ❒Same as patient ❒Same as responsible party ❒Other:_____

Subscriber's Name *Last* *First* *Middle Initial*	Date of Birth	Social Security Number	Sex

Employer	Home Phone Number	Work Phone Number
	( )	( )

I certify that the information reported above is correct and complete and that I will notify GI Associates of Maryland, immediately of any changes.

Signature of Patient/Parent/Guardian/Guarantor _____ Print Name _____ Date _____

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