MOUNTAIN LAUREL MEDICAL CENTER

PATIENT REGISTRATION FORM
Please Print Clearly
Please provide insurance card and a photo I.D.

1027 Memorial Drive
Oakland, MD 21550
301-533-3300

INFORMATION

Patient's Last Name: _____ **First:** _____ **Middle:** _____

Patient's Date of Birth: _____/_____/_____ _____ Male _____Female Nickname: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

☐ Physcial Address is Same Religion: _____ Previous Name: _____

Physical Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____-_____-_____ Cell Phone: _____-_____-_____ Marital Status: _____

Email Address: _____ Current Primary Care Physician: _____

Patient's Social Security #: _____ Is Patient a Student: ☐ Full ☐ Part Veteran: ☐ Yes ☐ No

Race:
- ☐ American Indian
- ☐ Asian
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Multiracial
- ☐ Native Hawaiian
- ☐ White (not Hispanic)

Employment Status:
- ☐ Full/Part Time
- ☐ Migrant Worker
- ☐ Seasonal Worker
- ☐ Not Employed

Housing Status:
- ☐ Have Home
- ☐ Transitional
- ☐ Shelter
- ☐ Street
- ☐ Living with Someone Else

Do you speak English? ☐ Yes ☐ No

Is your condition the result of a **work injury or auto accident**? ☐ Yes ☐ No

Person to Contact in an Emergency : _____ Emergency Phone: _____-_____-_____

Primary Insurance: _____ **Policy #** _____ **Group #** _____

Billing Address: _____ City/State/Zip: _____

Name of Policyholder: _____ Relationship to Patient: _____

Birthdate of Policyholder: _____/_____/_____ Copay Amount: _____ Effective Date: _____

Secondary Insurance: _____ **Policy #** _____ **Group #** _____

Billing Address: _____ City/State/Zip: _____

Name of Policyholder: _____ Relationship to Patient: _____

Birthdate of Policyholder: _____/_____/_____ Copay Amount: _____ Effective Date: _____

Information

Employer Name: _____ ☐ Self Work Phone: _____-_____-_____

Employer Address: _____ City/State/Zip: _____

How were you referred to us? (Circle One)

By Your Employer: _____ ER Physician: _____

Insurance Company: _____ Family/Friend: _____

Hospital: _____ Other: _____

Website/Facebook: _____ Circle One : Newspaper/Radio/Billboard/Brochure/Postcard

Responsible Party

Is someone other than the patient responsible for healthcare decisions? If yes, fill in below

Are you related to the patient: _____ Are you a Foster Parent: _____ How are you related: _____

Parent/Guardian Full Name: _____ Social Security #: _____

Address (if different): _____ Telephone: _____-_____-_____

City: _____ State: _____ Zip Code: _____ Guardian Birthdate: ____ /____ /_____

Guardian's Employer: _____ Employer Telephone: _____-_____-_____

Is Guardian a veteran? Yes ☐ No ☐

Number of persons in household: _____ Head of Household: _____

Annual household gross income: _____

Mountain Laurel Medical Center offers a sliding fee program for those patients who qualify. Are you interested in more information?

☐ Yes ☐ No ☐ Already enrolled

Assignment of Benefits

I authorize payment of insurance benefits to Mountain Laurel Medical Center for medical services rendered to me. I understand that I am responsbile for payment of fees for medical services rendered to me that are not covered by insurance or other third party payers, including copay, deductible and non-covered amounts. I am aware that without the proper insurance information, Mountain Laurel Medical Center is not able to accurately submit claims on my behalf. I attest that the information provided above is correct.

Signed:_____ Date: _____