THE MARYLAND PEDIATRIC GROUP, L.L.C./PEDIATRIC CONSULTANTS, P.A.

PATIENT REGISTRATION

Date: _____ Primary Care Doctor: _____

Referring M.D. (**Dr. Schuberth and Jane Spath patients only**):

_____ Referring M.D. Phone:_____

SECTION I: DEMOGRAPHIC INFORMATION

Patient/Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____
D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____
Children live with (Circle One): Parents Mother Father Other: Explain_____

Ethnicity**:* Hispanic / Non-Hispanic / Unknown ***Race: Asian / Black / Hawaiian / White

In order to maintain compliance with The American Recovery and Reinvestment Act (ARRA) we are required to obtain the above information.

Home Mailing Address:

_____
(Street or PO Box) *(City)* *(State & Zip)*

Primary Telephone Number**: **Circle One *Home /Cell/Other* (_____) _____ - _____

10807 FALLS ROAD, SUITE 200, LUTHERVILLE, MD 21093 PHONE: (410) 321-9393 FAX: (410) 825-4945

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Mary B. Garza, M.D. Jason P. Cervenka, M.D Lauren P. Mendelsohn-Levin, M.D
Elizabeth A. Donahoo, M.D. Noel B. Morelli, P.A.-C Stephanie M. Eyler, CPNP Anna Curren, CPNP
Emeritus: Arnold T. Sigler, M.D., Dennis L. Headings, M.D., Alan M. Lake, M.D.

SECTION II – PREFERRED METHOD OF CONTACT **(Patient 18 years and over or Primary Contact 1 to complete Preferred Method of Contact information below)**

How would you ideally prefer to be contacted regarding (circle one):

***Medical Issues**:* Home Phone / Cell Phone
***Appointment Reminders**:* Home Phone/ Cell Phone /Home Email
Recall Notices: Home Phone / Cell Phone/ Home Email

Home Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Home Email: _____

SECTION III – CONTACT INFORMATION

IF 18 YEARS OF AGE OR OLDER, DO NOT COMPLETE THIS SECTION PRIMARY CONTACT 1 OR CONTACT 2

Primary Contact 1 (Person who typically brings patient for medical care and will receive billing statements):

Name: _____ *Relation to Patient*: _____
Lives with patient? Yes / No ***If No, Provide Address below:***

_____
(Street or PO Box) *(City)* *(State and Zip Code)*
Date of Birth: ____ / ____ / ____ *Social Security #:* ____ - ___ - _____
Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____
Home Email: _____ *Work Email:* _____
Employer: _____ *Occupation:* _____

Contact 2: *Name*: _____ *Relation to Patient*: _____
Lives with patient? Yes / No ***If No, Provide Address below**:*

_____
(Street or PO Box) *(City)* *State and Zip Code)*

Date of Birth: ____ / ____ / ____ *Social Security #:* ____ - ___ - _____
Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____
Home Email: _____ *Work Email:* _____
Employer: _____ *Occupation:*_____

SECTION IV – EMERGENCY CONTACTS

Emergency Contacts (other than parents if under 18 years of age)
1: _____ Relationship: _____ *Phone*: (____) _____ - _____
2: _____ Relationship: _____ *Phone*: (____) _____ - _____

SECTION V - SEPARATED OR DIVORCED

Payment is the responsibility of the parent accompanying the child to the medical appointment. This is very important so that there are no misunderstandings regarding the necessary treatment for your child.

If parents are divorced or separated, please fill out this section:

*Who has custody?*_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes /No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction. (Add additional blank page (if needed)

SECTION VI – INSURANCE INFORMATION

Primary Policy: *Policy Holder's Name*: _____
Policy Holder's Relationship to Patient: _ _____
Policy Holder's Birth Date: _____ SSN: _____ *Sex:* Male / Female
Insurance Carrier: _____ Effective Date:_____
ID# _____ *Group #* _____

Secondary Policy: *Policy Holder's Name*: _____
*Policy Holder's Relationship to Patient:*_____ *Policy Holder's Birth Date*: _____ SSN: _____ *Sex:* Male / Female
Insurance Carrier: _____ Effective Date:_____
ID# _____ *Group #* _____

SECTION VII – ASSIGNMENT OF BENEFITS

I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company (s), I will be held directly responsible for all fees incurred with The Maryland Pediatric Group L.L.C./Pediatric Consultants.

I understand that I am responsible for copayments, coinsurance, deductibles, services not covered by my insurance. I acknowledge that I am responsible for payment in full in the event the provider of services does not participate with my insurance plan. I also understand that I am responsible for providing a current referral form at the time of service (before services are rendered) if required by my insurance plan. If I elect to see the provider of services without the necessary referral form, I understand that I am responsible for payment in full at the time of service and that my insurance may deny my claim (Refer to Self-Pay Policy on Financial Disclosure). I authorize payment of medical benefits to the physician or provider for all services rendered. I also authorize the release of any medical information requested for the processing of the claims for myself (or my minor child).

I have received information regarding the privacy practices of The Maryland Pediatric Group L.L.C./Pediatric Consultants as it relates to me or my child (ren) as defined by state and federal regulations.

Circle One:
Patient/Parent/Legal Guardian _____Date_____
Signature

_____
Print Name

Revised 12/27/13, 11/6/15, 3/8/16, 3/29/16, 3/15/17

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