

Sherif Hassan / Maryland Urgent Care9831 Greenbelt Rd, Suite 103
Lanham, Maryland 20706
(301) 277-3555**PATIENT REGISTRATION RECORD**

*** PLEASE PRINT ***

Today's Date:

ACCT _____

PATIENT'S NAME:

LAST FIRST MIDDLE

STREET: APARTMENT NO.: SEX: (Circle) DATE OF BIRTH:

MALE FEMALE / /

CITY: STATE: ZIPCODE: SOCIAL SECURITY NUMBER:

- -

HOME TELEPHONE: WORK TELEPHONE: DRIVER'S LICENSE NUMBER:

RESPONSIBLE PARTY:

LAST FIRST MIDDLE

STREET: APARTMENT NO.: SEX: (Circle) DATE OF BIRTH:

MALE FEMALE / /

CITY: STATE: ZIPCODE: SOCIAL SECURITY NUMBER:

- -

HOME TELEPHONE: WORK TELEPHONE: DRIVER'S LICENSE NUMBER:

EMPLOYED BY: POSITION: PHONE:

EMPLOYER'S ADDRESS:

SPOUSE'S FULL NAME: BIRTH DATE: HOME PHONE:

SPOUSE'S EMPLOYER: POSITION: WORK PHONE:

INSURANCE INFORMATION:

INSURANCE COMPANY FULL NAME: GROUP NUMBER: I.D. NUMBER:

Name of Group Insured: Certificate Holder's Full Name:

MEDICARE NUMBER: MEDICAID NUMBER: MEDICAL ASSISTANCE NUMBER:

BLUE CROSS/BLUE SHIELD I.D.#: D.C.: Md.: Other:

IS THIS A LEGAL CASE? Yes ____ No ____ IS THIS A WORKER'S COMPENSATION CASE? Yes ____ No

DATE OF ACCIDENT/INJURY: EMPLOYER AT TIME OF ACCIDENT/INJURY:

AUTOMOBILE INSURANCE COMPANY'S NAME: POLICY #:

ADDRESS (if known): CLAIM #:

ATTORNEY'S NAME: ATTORNEY'S PHONE NUMBER:

ATTORNEY'S ADDRESS:

NOTE: IF PATIENT IS A MINOR, parent or guardian must answer and sign form!!!**-- AUTHORIZATIONS --**

I, _____, hereby authorize **Sherif Hassan, M.D.** to apply for benefits on my behalf for services rendered to me (or my minor child) and request that payment be made by _____ Insurance Company and that payment be sent directly to **Sherif Hassan, M.D.**

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me (or my minor child), and if my account is turned over to an attorney for collection, I agree to pay any reasonable legal fees (25% is deemed reasonable) court costs, and other expenses incurred as a result of said collection. The undersign agrees that should suit be filed, venue (location of suit) shall be in Prince George's County, Maryland, venue in any other counties being waived hereby

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits. Furthermore, *I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.*

Date

SIGNATURE (By Patient or Responsible Party)