Faith Hackett, M.D./Jeffrey Schmidlein, M.D./Jacalyn Ginsburg, D.O.
844 Ritchie Highway, Suite 206
Severna Park, MD 21146
Phone: 410-647-8300/Fax: 410-315-8444

Patient Registration Form

Patient Information

Patient's Name: _____ Date of Birth: _____

Primary Care Physician: _____

Sex (Circle): Male / Female Marital Status (Circle): Single / Married / Divorced / Widow / Widower

Address: _____

City _____ State ___ Zip Code _____

Phone Numbers (for pediatric patients, please specify to whom the cell phone belongs):

Home _____ Cell _____ Work _____

Social Security Number: _____ Email: _____

Race (You May Refuse): _____ Preferred Language: _____

Ethnicity (Please Circle – You May Refuse): Hispanic or Latino / Not Hispanic or Latino

Name of Preferred Pharmacy: _____ Zip Code of Preferred Pharmacy: _____

Name of Parents (Pediatric Patients Only): Mother _____ Father: _____

Emergency Contact: Name _____

Home Phone _____ Cell _____

Person Responsible for Any Balance: Name _____

Relationship to Patient _____

Home Phone _____ Cell _____

Patient Registration Form

Primary Insurance Information

Name of Primary Health Insurance: _____ PCP Copay: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Policy Number: _____ Group Number: _____

Subscriber's Social Security Number: _____ Effective Date: _____

Patients Relation to Subscriber (Circle): Self / Spouse / Child / Other

Mail-Away Rx Plan: _____

Secondary Insurance Information

Name of Secondary Health Insurance: _____ PCP Copay: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Policy Number: _____ Group Number: _____

Subscriber's Social Security Number: _____ Effective Date: _____

Patients Relation to Subscriber (Circle): Self / Spouse / Child / Other

Mail-Away Rx Plan: _____

Assignment of Benefits:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for any non-covered services, co-pay, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process my claims.
- A fee for no shows may apply.

Signed: _____ Date: _____