

NEW DEMOGRAPHIC FORM

July 2011

Patients:

All patients are required to complete a new demographic sheet. We have updated our system to better assist you in the future.

There are required fields that need to be reported to the government. In order to comply with this request we need each patient to complete this new demographic form in its entirety.

Once completed and signed please return to the front desk receptionist.

If you would like to become web enabled, this is a website that has access to a limited view of your medical records. In the future you will be able to send and receive messages and obtain test results through this portal. It is a secured website and if you are interested please mark this on the demographic sheet, supply your e-mail address and the front desk staff will update your information. You will receive an e-mail confirmation that will include your temporary password and log in. Front desk staff will print and give you a hardcopy of this information as well.

The access is <https://mycw15.eclinicalweb.com/portal875/jsp/login.jsp>

The patient portal is a work in progress. We expect it to be completed in the next month. To get the update on its completion please access our website at www.marylandendocrine.com

Maryland Endocrine, P.A.

Account# _____

Date: _____

PATIENT INFORMATION

Name: _____
Last First MI

* Date of Birth: _____

Address: _____

* Race: _____

Apt: _____ P O Box _____

City: _____ State _____ Zip _____

* Ethnicity: _____

Social Security #: _____

* Preferred Language: _____

Marital Status: _____ Sex: (M/F/TG) _____

Home #: _____ Cell #: _____

Primary Contact Number:

(H) (C) (W) Circle one.

Work #: _____ Ext: _____

E-Mail Address: _____

Okay to leave message:

(Y/N) _____

Web Enabled: (Y/N) _____

Employed (Y/N) _____ Student (PT/FT) _____

Appointment Contact Method

Phone (Y/N) _____ E-Mail (Y/N) _____

Emergency Contact person: _____

Relationship: _____ Number: _____

Employer: _____

Primary Care MD: _____

Phone number: _____

Specialist MD: _____

Phone Number: _____

Specialist MD: _____

Phone Number: _____

PHARMACIES:

Local Pharmacy Name: _____

Number: _____

Mail Order Pharmacy Name: _____

Number: _____

DEMOGRAPHIC FORM PAGE II

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

Tertiary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I authorize Maryland Endocrine, P.A. to apply for benefits on my behalf for covered services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. (Or in the case of Medical Part B benefits to Social Security Administration and Health Care Financing Administration).

I authorize payment of medical insurance benefits which are payable to me under the terms of my insurance to be paid directly to Maryland Endocrine, P.A. for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

This authorization may be revoked by either me or my insurance carrier at any time in writing. I understand and agree that I am financially responsible for charges not paid by my insurance company.

Signature of Patient, Insured or Beneficiary

Date: _____

I allow MARYLAND ENDOCRINE, P.A. to release any information relevant to my care to:

1) _____ Relationship _____

2) _____ Relationship _____

I the undersigned acknowledge everything on this form is correct to the best of my knowledge.

Signature of Patient/Guardianship

Date: _____