DRS. KROOPNICK & SHERMAN, P.A.

4000 Old Court Road, Suite 300
Pikesville, MD 21208

PATIENT REGISTRATION - *Please Print Clearly*

PATIENT NAME First Middle Last			DATE OF BIRTH	AGE
HOME ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
OCCUPATION / EMPLOYED ☐ FT ☐ PT RETIRED ☐ STUDENT ☐	SOCIAL SECURITY NO.	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W	SEX	HOME PHONE
EMPLOYER (or previous employer, if retired)	ADDRESS			WORK PHONE
SPOUSE (OR PARENT) NAME	ARE YOU ALLERGIC TO ANY MEDICATION?			
NEAREST RELATIVE / FRIEND	RELATIONSHIP	HOME PHONE		WORK PHONE
RELATIVE / FRIEND ADDRESS				
WHO MAY WE CONTACT IN AN EMERGENCY?	ADDRESS			TELEPHONE

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check or Money Order.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Other (Specify) ________________

I agree to promptly pay all charges when billed for medical services rendered
And accept legal responsibility for any and all charges for the patient named above. X ________________

BILLING AND INSURANCE INFORMATION

SEND BILL TO					
	FIRST NAME	LAST NAME			RELATIONSHIP TO PATIENT
	HOME ADDRESS			CITY	ZIP CODE
	EMPLOYER			WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME			ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS			SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	EMPLOYER	SEX	WORK PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS			HOME PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME			ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS			SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	EMPLOYER	SEX	WORK PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS			HOME PHONE	SUBSCRIBER'S DATE OF BIRTH

PATIENT AUTHORIZATION

I, ____________________, hereby authorize Dr.s Kroopnick & Sherman, P.A., To apply for benefits on my behalf for covered services rendered. I request payment from Blue Shield of Maryland, Medicare, and/or ________________ Insurance Company, be made directly to the above-named
(Name of Other insurance Co)
provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished to me by that physician/ supplier. I authorize any holder of medical information about me to release to ________________ any information needed to determine these benefits payable for related services.
(Name of Medigap Carrier)

________________ Date

________________ Signature of Subscriber or Beneficiary

ACCOUNT NUMBER

PLEASE COMPLETE INFORMATION REQUESTED ON THE REVERSE SIDE

GENERAL MEDICAL INFORMATION

DESCRIBE CURRENT MEDICAL PROBLEM/REASON FOR TODAY'S VISIT	
PRESENT MEDICINES	ALLERGIES TO MEDICINES
PREVIOUS OR OTHER MEDICAL PROBLEMS	

TERITIARY INSURANCE

Complete Only If Patient Has Third Party Insurance Company

TERTIARY INSURANCE				
	INSURANCE COMPANY NAME — IS THIS THROUGH EMPLOYER ☐ OR INDIVIDUAL ☐		ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS		RECIPROCITY NUMBER	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH