UNIVERSITY of MARYLAND
COMMUNITY MEDICAL GROUP

REGISTRATION FORM

Please Print Clearly

Date Completed: ________________ ***Form Completed By:*** ______________________________________

PATIENT DEMOGRAPHICS

Last Name: ________________________ First Name: ____________________ Middle: ____________________

Alias/ Nickname: ____

Social Security #: ____________________ Gender: ___________ Date of Birth: _______________ Age: ____

Permanent / Physical Address (Required) – *If PO Box is used for mailing please list as Confidential Address*

Street Address:____

City: __________________________ State:_________ Zip Code:____________ County:_________________

Temporary Address ☐ **Confidential Address** ☐ (Not Required) Start Date:______ End Date: _____

Address: ____

City: __________________________ State:_________ Zip Code:____________ County:_________________

Contact Phone Numbers:

Home: _________________________ Work: ______________________ Cell / Mobile: _____________________

GENERAL INFORMATION

Interpreter Needed? Yes ☐ **No** ☐ Preferred Language: _____________________________________

Marital Status: _______________________ Spouse's Name: ___________________________________

Religion: ___________________________

Hispanic / Latino Ethnicity? Yes ☐ NO ☐ Country of Birth: ____________________________

<u>Check all Race Categories the patient self-identifies as</u>:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White / Caucasian
- ☐ Declined to Answer

REFERRING PHYSICIAN

Name: _____________________________________ Phone Number: ___________________________________

Location: ____

PRIMARY CARE PHYSICIAN

Name: _____________________________________ Phone Number: ___________________________________

Location: ____

Approximate start date of care:______________________

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EMPLOYMENT STATUS (Please Check One)

Employed: Full Time ☐ Part Time ☐ Self Employed ☐ Active Military ☐

Occupation: ______________________ Employer: ______________________

Address: ______________________

Student : Full Time ☐ Part Time ☐

Retired: ☐ (Date) ______________ Company: ______________________

Disabled: ☐ (Date) ______________

EMERGENCY CONTACTS

Contact #1 Name: ______________________ Relationship: ______________

Home: ______________ Work: ______________ Cell / Mobile: ______________

Contact #2 Name: ______________________ Relationship: ______________

Home: ______________ Work: ______________ Cell / Mobile: ______________

GUARANTOR OF ACCOUNT (required if patient is a minor)

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other______________

Last Name: ______________ First Name: ______________ Middle: ______________

Alias/ Nickname: ______________________

Social Security #: ______________ Gender: ________ Date of Birth: ______________ Age: _____

Billing Address: ______________________

City: ______________ State:________ Zip Code:__________ County:______________

INSURANCE INFORMATION

Primary Insurance:______________________

Subscriber's Name:______________________ Relationship to Patient:______________

Date of Birth:______________ SS#______________ Employer:______________

Patient Policy #: ______________________ Subscriber Policy #: ______________

Group # (if applicable) ______________

Secondary Insurance:______________________

Subscriber's Name:______________________ Relationship to Patient:______________

Date of Birth:______________ SS#______________ Employer:______________

Patient Policy #: ______________________ Subscriber Policy #: ______________

Group # (if applicable) ______________