Patient Information

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Sex: M / F Date of Birth: _____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ E-mail address_____

Social Security Number: _____/_____/_____

Emergency Contact Information
Name: _____ Phone: _____
****

Insurance Information

Primary coverage:	Secondary Coverage:
Company: _____	Company: _____
Insured: _____	Insured: _____
Relationship: _____ DOB: _____	Relationship: _____ DOB: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____

****

Insurance Authorization

I authorize Severna Park Medical Associates, to apply for benefits on my behalf for services rendered Severna Park Medical Associates. I request payment from my insurance company be made directly to Severna Park Medical Associates. 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 claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided.

I have received / read a copy of the **Notice of Privacy Practices: Severna Park Medical Associates**

Signature:_____Date:_____