Calvert
SLEEP CENTER

410-414-6185
995 PRINCE FREDERICK BLVD, STE 101
PRINCE FREDERICK, MD 20678

Registration Form

Date _____ Home Phone: _____ Cell: _____

PATIENT INFORMATION

Name _____ Social Security# _____
Last *First* *Middle Initial*

Address _____ City _____

State _____ Zip _____ Email _____ Sex ❑ M ❑ F Age _____

Birth date _____

❑ Married ❑ Single ❑ Minor ❑ Separated ❑ Widowed ❑ Partnered

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

How did you hear about us? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account: _____
Last *First* *Middle Initial*

Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Group # _____ Subscriber# _____

Social Security / I.D.# _____

Name of other dependents covered under this plan _____

_____

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ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber name _____ Birth date _____

Address (if different from patient's) _____ Phone _____

Name of Insurance Company(ies)

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Group # _____ Subscriber# _____

Social Security / I.D.# _____

Name of other dependents covered under this plan _____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have Insurance coverage with _____ and assign directly to Kim L. Goring, M.D., all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment tor services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient