Asthma Sinus Allergy Program at
Greater Baltimore Medical Center
Physicians Pavilion North I
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NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION: Last Name: _____ First Name: _____ MI: ___

Sex: ___ Marital Status: ___ Date of Birth: _____ **Email:** _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Occupation: _____ Employer: _____

EMERGENCY CONTACT: Name: _____ Relationship: _____ Phone: _____

PHARMACY: Name, Location: _____ Phone: _____ Fax: _____

Is the patient the Policy Holder? ☐ Yes. ☐ No. **If not, Guarantor Information is needed if patient is a minor.**

GUARANTOR/RESPONSIBLE PARTY: Name: _____ Home Phone: _____

Work Phone: _____ Address: _____ City, State: _____ Zip: _____

PRIMARY CARE PHYSICIAN: Name: _____ Phone: _____

Address: _____ City, State: _____ Zip: _____

REFERRING PHYSICIAN: Name: _____ Phone: _____

Address: _____ City, State: _____ Zip: _____

REFERRAL SOURCE: ☐ Physician Referral above ☐ Patient Referral, Name: _____

☐ Post card ☐ Newspaper ☐ Health Fair ☐ Web site ☐ Television ☐ Sign, Location: _____

INSURANCE INFORMATION:

Primary Insurance

Name of Insurance Carrier: _____ Policy Number: _____

Group/Identification Number: _____ Effective Date: _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Secondary Insurance

Name of Insurance Carrier: _____ Policy Number: _____

Group/Identification Number: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

AUTHORIZATION AND AGREEMENT

I hereby authorize the Asthma Sinus Allergy Program at GBMC (ASAP@GBMC) to directly receive payment of pertinent insurance benefits; to release information including protected health information to insurance companies and other related third parties as needed in relation to the filing for or collection of payment for provided services; to obtain records from other sources as needed in relation to patient diagnosis and treatment; and to convey information through various means as needed in accordance with the Notice of Privacy Practices, a copy of which was made available to me.

I hereby acknowledge that I am personally responsible for all co-payment, deductibles, non-covered services and required referrals according to my insurance policy. I agree to pay all applicable charges accrued and to promptly pay any balance in full. I understand that my account will be charged $25.00 for any checks returned due to non-sufficient funds. I agree to promptly alert ASAP@GBMC should there be any changes related to insurance and other information I provided above.

Name and Signature of Responsible Party: _____ ***Date:*** _____

Print Form