Capitol Care Medical Associates, PLLC
7700 Old Branch Avenue, Suite A105
Clinton, MD 20735

REGISTRATION FORM

(Please Print)

Today's date:

Patient's Last Name: **First** **Middle**

Marital Status (circle one)

Single/ Married / Divorced / Separated / Widow / Civil Union

Home Phone# **Cell Phone#**

Which is your preferred contact number?

Home/Cell/Work _____

Email Address:

Date of Birth:_____**Age:**_____**Gender** _____**Gender Identity**_____

Street Address:_____

PO Box:_____**City:**_____**State:**_____**Zip Code:**_____

Occupation:_____**Employer:** _____**Work phone#:**_____

Referring Provider Name:_____**Address:**_____

Primary Care Physician Name:_____ **Address:**_____

_____

INSURANCE INFORMATION
(Please give insurance card to the receptionist)

Person responsible for bill: Birth date: Address (if different):

Name of Primary Insurance: Subscriber's Name:

Policy ID Number: Group#

Patient's relationship to subscriber: (circle one) Self Spouse Other

Name of Secondary Insurance (if applicable): Subscriber's Name:

Policy ID Number: Group#:

Patient's relationship to subscriber: (circle one) Self Spouse Other

IN CASE OF EMERGENCY

Name of local relative or friend: Relationship to Patient: Phone#

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Capitol Care Medical Associates, PLLC to release any information to process my claims.

Patient/Guardian signature Date