

Kentlands Medical Associates P.C
344 Main Street, Suite 100
Gaithersburg, MD 20878
(240)632-0333

PATIENT REGISTRATION

New Patient Update Worker's Compensation

Date _____ Last Name: _____ First Name: _____ M _____

Home Address _____

City: _____ State: _____ Zip _____

SSN _____ Date of Birth ___/___/___ Sex M / F Home Telephone _____
Cell # _____

Check appropriate box: Minor Single Married Divorced Separated

Spouse's or Parent's Name: _____ How did you hear about us? _____

Patient's or Parent's Employer _____ Work Phone _____

Employer' Address _____

INSURANCE INFORMATION

Insurance Company: _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

Policy Holder's Name, if different than Patient _____

Relationship to Patient _____

Policy Holder's Date of Birth, if different than Patient ___/___/___ SSN: _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient: _____

Address _____

Home and/or Cell # _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
Signature of patient or parent if minor

Date

Health History

Please list all medications you are currently taking (include nonprescription): _____

Please list all allergies: _____

Please inform us of pertinent medical history (including family history): _____

Have you ever had the following? (Please Circle yes or no)

- | | | | | | |
|------------------------|----|-----|-------------------------|----|-----|
| 1. Chickenpox | no | yes | 14. Hepatitis | no | yes |
| 2. Scarlet Fever | no | yes | 15. Migraine Headaches | no | yes |
| 3. Pneumonia | no | yes | 16. Tuberculosis | no | yes |
| 4. Rheumatic Fever | no | yes | 17. Diabetes | no | yes |
| 5. Heart Disease | no | yes | 18. Cancer | no | yes |
| 6. Heart Murmur | no | yes | 19. Glaucoma | no | yes |
| 7. Arthritis | no | yes | 20. Hernia | no | yes |
| 8. Anemia | no | yes | 21. High Blood Pressure | no | yes |
| 9. Bladder Infections | no | yes | 22. Hemorrhoids | no | yes |
| 10. STDs | no | yes | 23. Asthma/Bronchitis | no | yes |
| 11. Epilepsy | no | yes | 24. Skin Disease | no | yes |
| 12. Bleeding Tendency | no | yes | 25. Depression | no | yes |
| 13. Sexual Dysfunction | no | yes | 26. Any other disease | no | yes |

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changed in my medical status.

Signature of Patient, Parent or Guardian

Date

Doctor's Review

Signature of Doctor

Date