

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: _____