PARK MEDICAL ASSOCIATES, LLC

10755 FALLS ROAD, SUITE 200 LUTHERVILLE, MD 21093

SELECT PHYSICIAN

☐ BELITSOS ☐ GARG ☐ MOLAVI ☐ MOLINARO ☐ SAVADEL ☐ SIMONSON ☐ STEINER

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	DOB:
SSN: ☐ M ☐ F ☐ Non-Binary	MARITAL STATUS:	PREFERED LANGUAGE:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
CELL PHONE:	HOME PHONE:	WORK PHONE:	EXT:
RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to answer	ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer	EMAIL:	☐ EMPLOYED ☐ STUDENT
NAME OF EMPLOYER:	OCCUPATION:		
EMPLOYER ADDRESS:	CITY/STATE/ZIP CODE:		
EMERGENCY CONTACT NAME:	RELATIONSHIP:	PHONE NUMBER:	
PREFERED PHARMACY:	PHARMACY ADDRESS:	PHARMACY PHONE NUMBER:	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:	PRIMARY INSURANCE PHONE NUMBER:		
MEMBER ID:	POLICY #:	GROUP #:	
INSURANCE ADDRESS:	CITY/STATE/ZIP CODE:	EFFECTIVE DATE:	
ARE YOU THE POLICYHOLDER? ☐ YES ☐ NO	POLICYHOLDER NAME:	POLICYHOLDER DOB:	POLICYHOLDER RELATIONSHIP:
SECONDARY INSURANCE NAME:	SECONDARY INSURANCE PHONE NUMBER:		
MEMBER ID:	POLICY #:	GROUP #:	
INSURANCE ADDRESS:	CITY/STATE/ZIP CODE:	EFFECTIVE DATE:	
ARE YOU THE POLICYHOLDER? ☐ YES ☐ NO	POLICYHOLDER NAME:	POLICYHOLDER DOB:	POLICYHOLDER RELATIONSHIP:
PRESCRIPTION CARD COMPANY NAME:	PRESCRIPTION CARD PHONE NUMBER:	MEMBER ID:	
RXBIN:	RXGRP:	RXPCN:	EFFECTIVE DATE:

PAYMENT OF BENEFITS

I authorize Park Medical Associates, LLC to file insurance on my behalf and release any medical or other information necessary to process my claims. When applicable, I authorize the payment of benefits directly to the physician. I understand Park Medical Associates participates with Carefirst, Cigna, Johns Hopkins EHP, and the Medicare network. Specialized testing services sent to an outside reference lab will be billed separately by that testing facility. I understand that I am responsible and agree to pay for any balance not covered by my insurance.

Signature:____ Date: ________________________