PARK MEDICAL ASSOCIATES, LLC **PARK MEDICAL LABORATORY**
10755 FALLS RD. SUITE 200 LUTHERVILLE, MD 21093

PATIENT REGISTRATION: Fill in online and print, or print and fill out using black ink. Use the [TAB] key or Right Arrow key to move to the next field. To move backward, use the Left Arrow key. Pressing F1 in select fields will provide helpful hints on how to enter the data.

Primary Physician:

☐BELITSOS ☐BYRD ☐HADLEY ☐MAGAZINER ☐MOLAVI ☐MOLINARO ☐NEWMAN ☐POZEFSKY
☐PRESSMAN ☐SAVADEL ☐SEIFTER ☐SHISHODIA ☐SIMONSON ☐STEINER ☐WILKENFELD

PLEASE PRINT **Today's Date**: **Appt. Date**: **Appt. Time**:

PATIENT INFORMATION

LAST NAME	FIRST	MI	Social Security #	JHH HIST#

ADDRESS	REFERRING DOCTOR

CITY	STATE	ZIP or Postal Code	COUNTRY	SEX ☐M ☐F	DATE of BIRTH	MARITAL STATUS ☐M ☐S ☐W ☐D ☐Other

PREFERRED LANGUAGE: ☐ English ☐ Other (please specify) ☐ Decline to answer

RACE: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Decline to answer

ETHNICITY: Are you of Hispanic Origin? ☐ YES ☐ NO ☐ Decline to answer

HOME PHONE	CELL PHONE	WORK PHONE	EXT

eMAIL ADDRESS

NAME OF EMPLOYER	OCCUPATION

EMPLOYER ADDRESS

CITY	STATE	ZIP

☐ EMPLOYED STUDENT: ☐ FULL-TIME ☐ PART-TIME

SPOUSE'S NAME	
SPOUSE'S OCCUPATION	SPOUSE'S DATE OF BIRTH
SPOUSE'S EMPLOYER	
SPOUSE'S EMPLOYER'S ADDRESS	

CITY	STATE	ZIP

SPOUSE'S WORK PHONE	EXT	SPOUSE'S' CELL PHONE

PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP

WORK PHONE	EXT

HOME PHONE	CELL PHONE

PHARMACY NAME

PHARMACY ADDRESS

PHARMACY PHONE

INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE	NAME OF SECONDARY INSURANCE

ADDRESS	ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

PHONE	EFFECTIVE	PHONE	EFFECTIVE

POLICY #	GROUP #	POLICY #	GROUP #

IS POLICY HOLDER THE PATIENT? YES ☐ NO ☐ IS POLICY HOLDER THE PATIENT? YES ☐ NO ☐

POLICY HOLDER LAST NAME	FIRST	MI	POLICY HOLDER LAST NAME	FIRST	MI

ADDRESS	ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

SOCIAL SECURITY #	SEX	DATE OF BIRTH	SOCIAL SECURITY #	SEX	DATE OFBIRTH

RELATIONSHIP OF THE PATIENT TO THE POLICY HOLDER	RELATIONSHIP OF THE PATIENT TO THE POLICY HOLDER

EMPLOYER OF POLICY HOLDER if not listed above	EMPLOYER OF POLICY HOLDER if not listed above

PAYMENT OF BENEFITS

I authorize Park Medical Associates and Park Medical Laboratory to file insurance on my behalf and release any medical or other information necessary to process my claims. When applicable, I authorize payment of benefits directly to the physician or laboratory. I understand that Park Medical Laboratory and the physicians of Park Medical Associates (excluding John Aucott, M.D.) participate in all Cigna (except Worker's Comp) and CareFirst networks. I understand that the physicians and the lab also participate with EHP. I understand that the Park Medical physicians do ***not*** accept Medicare assignment (except for Dr. Seifter). I understand that the physicians and the lab do ***not*** participate with any other commercial insurance or HMO. Park Medical Laboratory participates with Medicare. 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 _____