Georgetown University Hospital   MedStar Health

PATIENT REGISTRATION

GEORGETOWN PHYSICIANS GROUP

Washington, DC 20007

PATIENT

Name *(Last, First, Middle)*: ____________________

Address: ____________________

____

Phone: __________ SSN: __________

Date of Birth: __________

Age: ______ Sex: ______

Race: __________

M. Status: __________

Medical Record Number

Employer: ____________________

Address: ____________________

Occupation: __________ Phone: __________ Ext: ______

Emergency Contact Name: ____________________

Address: ____________________

____

Relationship: __________ Phone: __________

Next of Kin: ____________________

Address: ____________________

____

Relationship: __________ Phone: __________

PHYSICIAN

Primary Care Physician: ____________________

____

Address: ____________________

____

Phone: __________

Referring Physician: ____________________

____

Address: ____________________

____

Phone: __________

GUARANTOR

Guarantor Name (Bill To): ____________________

____

Address: ____________________

____

Phone: __________ SSN: __________

Guarantor's Employer: ____________________

____

Address: ____________________

____

Phone: __________

INSURANCE

PRIMARY CARRIER Name: ____________________

PRIMARY CARRIER Address: ____________________

____

Subscriber's Name: ____________________

Subscriber's Employer: ____________________

DOB: __________ SSN: __________

ID / Policy #: __________ Group #: __________

Effective Date: __________ Expiration Date: __________

SECONDARY CARRIER Name: ____________________

SECONDARY CARRIER Address: ____________________

____

Subscriber's Name: ____________________

Subscriber's Employer: ____________________

DOB: __________ SSN: __________

ID / Policy #: __________ Group #: __________

Effective Date: __________ Expiration Date: __________

WORKER'S COMP: If work related injury, please complete this section:

Employer: ____________________ Injury Date: __________ Case Number: __________

Case Worker / Contact Name / Phone Number: ____________________

____

Insurance Carrier Name / Phone Number: ____________________

Claims Address: ____________________

____