

Today's Date	
Last Name	
First Name	
Middle Initial	
Birth Date	
Street Address	
City	
State	
Zip Code	
Home Phone Number	
Work Phone Number	
Cell Phone Number	
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Email Address	
Who Are You Seeing	<input type="checkbox"/> Dr. McNeill <input type="checkbox"/> Dr. Rosenberg <input type="checkbox"/> TEST ONLY
How/Who Referred You	
Referring address/phone	
Who is Your Primary Doctor	(if same as referred above write SAME)
Primary's address/phone	
Insurance Name (required)	
Do You Need A Referral?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
How Much Is Your Copay?	
Mailing address for ins co	
Effective Date of Insurance	
Expiration Date of Insurance	
Subscriber's Name	<input type="checkbox"/> Same as Patient or
Subscriber's Social Security #	<input type="checkbox"/> Same as Patient or
Subscriber's Date of Birth	<input type="checkbox"/> Same as Patient or
Relationship to Subscriber	<input type="checkbox"/> Same as Patient or
Policy Number	
Group Name	
Group Number	
Insurance Phone Number	
2nd Insurance	<input type="checkbox"/> N/A or
Subscriber's Name	<input type="checkbox"/> Same as Patient or <input type="checkbox"/> Same as Subscriber Above
Policy Number	
Group Name	
Group Number	

How Did You Hear About Us? Primary Care Doctor Referring Doctor Website Internet
 Frederick News Post Frederick Magazine Carroll County Times Elegant Living billboard
 Journal (WV) Express Newspaper Yellow Pages The Gazette A Friend _____
 Other (**please tell us**) _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY TO SECURE PAYMENT OF BENEFITS. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS AND AS AUTHORIZATION FOR PAYMENTS TO SEND TO MARYLAND SURGICAL CARE P.C. (dba: Capitol Vein & Laser Center)

RESPONSIBLE PARTY SIGNATURE (seal)

RELATIONSHIP

DATE