HOWARD COUNTY
Direct Primary Care

REGISTRATION FORM

(Please print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:				Marital status (circle one) Single / Mar / Div / Sep / Wid			
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ❑ M ❑ F		
Street address:		Social Security Number:	Home phone no.: ( )				
P.O. box:	City:	State:	ZIP Code:				
Occupation:	Employer:	Employer phone no.: ( )					
Other family members seen here:							

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Primary insurance:]					
Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY

Name of person to be reached:	Relationship to patient:	Home phone no.: ( )	Work/cell phone no.: ( )

Patient/Guardian signature *Date*