Complete Health Services
831 University Blvd. East, #36A
Silver Spring, MD 20903

Phone (301) 408-2720
Fax (301) 408-2725

PATIENT REGISTRATION

Patient Registration

Name _____

Address _____

City/State _____ **Zip Code** _____

Phone Home _____ **Cell** _____ **Work** _____

Social Security Number _____ **Gender** _____ **BirthDate** _____

Employer Name and Address _____

Emergency Contact -- Name _____

Relationship _____ **Telephone Number** _____

Primary Insurance

Name _____ **Policy No.** _____ **Group No.** _____
Policy Holder Name _____ **SSN:** _____
Relationship to Patient _____**Self** _____**Spouse** _____ **Child**

Secondary Insurance

Name _____**Policy No.** _____ **Group No.** _____
Policy Holder Name _____ **SSN:** _____
Relationship to Patient _____**Self** _____**Spouse** _____ **Child**

Authorization for Payment and/or Record Release

I request that payment from my authorized Insurance Carrier benefits be made on my behalf to Complete Medical Services Inc. for any services furnished to me. I authorize any holder of medical information about me to release it to my insurance company and its agents and/or any other insurance carriers for which I have coverage and any information needed to determine these benefits or the benefits payable for related services.

In the event that benefits are not paid by my insurance company, I will be responsible for the charges and agree to pay the charges from my office visit and any other procedures that were done.

_____

Patient Signature

Date