

Patient Registration

This patient registration form will be used for all Meritus Enterprises Inc. business units. You will only need to complete this form once a year for all visits to any MEI facility. MEI facilities are listed at the bottom of page 2.

Patient Information			
Name: (First, MI, Last)		Date of Birth:	
Address: (Street) :		Social Security Number:	
Address: (City, State, Zip)		Age:	Sex:
Home Phone:		Cell Phone:	
Race:	Ethnicity:	Language:	
Marital Status:	Email Address:		
<input type="checkbox"/> - Mailing Address Same as Patient Address			
Mailing Address: (Street)			
Mailing Address: (City, State, Zip)			
May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Employer Name:	
Work Phone:		PCP/Referring Doctor:	
May we leave a detailed message on your answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact: (Not living with you)			Home Phone:

Responsible Party/Guarantor Information	
<input type="checkbox"/> - Responsible Party Same as Patient	
Name: (First, MI, Last)	Date of Birth:
Address: (Street)	Social Security Number:
Address: (City, State, Zip)	Home Phone:
May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone:

Primary Insurance Information	
<input type="checkbox"/> - Self or Subscriber Name: (First, MI, Last) «PL1SubName»	
Address: (Street)	Date of Birth:
Address: (City, State, Zip)	Social Security Number:
Home Phone:	Sex:
Relationship to Patient:	
Insurance Company Name:	Policy ID:
Group ID:	Effective Date:
Employer Name:	Work Phone:

Patient Name: «PName»

Date of Birth: «PDOB»

Secondary Insurance Information

<input type="checkbox"/> - Self or Subscriber Name: (First, MI, Last)		
Address: (Street)		Date of Birth:
Address: (City, State, Zip)		Social Security Number:
Home Phone:	Sex:	Relationship to Patient:
Insurance Company Name:		Policy ID:
Group ID:		Effective Date:
Employer Name:		Work Phone:

Tertiary Insurance Information

<input type="checkbox"/> - Self or Subscriber Name: (First, MI, Last)		
Address: (Street)		Date of Birth:
Address: (City, State, Zip)		Social Security Number:
Home Phone:	Sex:	Relationship to Patient:
Insurance Company Name:		Policy ID:
Group ID:		Effective Date:
Employer Name:		Work Phone:

Confidentiality and Privacy under HIPPA (Health Insurance Portability and Accountability Act of 1996

- I acknowledge receipt of the Notice of Privacy Practices of Meritus Health System Organized Health Care Arrangement.

- I acknowledge having already received the Notice of Privacy Practices of the Meritus Health System Organized Health Care Arrangement.

Patient/Guardian Signature: _____ Date: _____

Digestive Disorders Consultants * Downtown Urgent Care * Jerry L Correces MD * North Pointe Internal Medicine * Potomac Family Medicine * Meritus Urgent Care * Robinwood Family Practice * Robinwood Internal Medicine * Robinwood Pain Center * Robinwood Surgical Associates * Smithsburg

Patient Name: «PName» Date of Birth: «PDOB»
Family Medical Center * Williamsport Family Practice * WillowWood Adult Medicine * White Oak
Pediatric and Adult Medicine * Women's Health Center * Women's Specialty Associates