

REGISTRATION FORM

(Please print clearly)

Signature Breast Care

Regina Hampton, M.D., P.C.
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Telephone: 301-552-7805
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Today's Date:

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss
Street Address		City	State	Zip Code
Home Phone # () -	Work Phone # () -	Cell Phone # () -	Email Address:	
Date of Birth: / /	Age	Social Security #:	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Minor <input type="checkbox"/> Partnered <input type="checkbox"/> Widow <input type="checkbox"/> Divorced	Gender <input type="checkbox"/> M <input type="checkbox"/> F

PRIMARY INSURANCE (PLEASE GIVE INSURANCE CARD AND ID TO RECEPTIONIST)

Occupation:	Insured's Employer:
Insured's Employer's Address:	
Insured's Name:	Insured's Date of Birth:
Does your insurance require a Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please obtain referral from Primary Care Doctor	
Policy/ID#:	Group#:
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Specialist Co-Payment Amount: \$

PLEASE INDICATE SECONDARY INSURANCE:

Insured's Name	Insured's Date of Birth	Policy/ID#:	Group#:
Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Specialist Co-Payment Amount: \$

HOW WERE YOU REFERRED TO OUR PRACTICE?

<input type="checkbox"/> Doctor /Name:	<input type="checkbox"/> Friend
<input type="checkbox"/> Hospital	<input type="checkbox"/> Internet:
<input type="checkbox"/> Family	<input type="checkbox"/> Family Member
<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Other/Magazine
Emergency Contact:	Phone:

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s) have insurance coverage with _____ and assign directly to **Regina Hampton, MD** all insurance benefits. If any, otherwise payable to me for the services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable to related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient