Maryland Primary Care Physicians

Patient Information Sheet

Patient Demographics

Name: _____
(last) (first) (middle)

Date of Birth: _____ Social Sec. #: _____

Maiden Name: _____ Nickname/Alias: _____

Permanent Address: _____

City: _____ Mobile Phone: _____

State: _____ Home Phone: _____

Zip Code: _____ Email: _____

Sexual Orientation and Gender Identity

Legal Sex	Gender Identity	Sex Assigned at Birth	Sexual Orientation
☐ Male	☐ Male	☐ Male	☐ Bisexual
☐ Female	☐ Female	☐ Female	☐ Choose Not to Disclose
☐ Non-Binary	☐ Transgender Male	☐ Not Recorded on Birth Certificate	☐ Gay
☐ Other	☐ Transgender Female	☐ Choose Not to Disclose	☐ Lesbian
☐ Unknown	☐ Choose Not to Disclose	☐ Uncertain	☐ Straight
☐ x	☐ Other: _____	☐ Unknown	☐ Something Else
			☐ Uncertain

Emergency Contact

Name: _____

Date of Birth: _____ Social Sec. #: _____

Address: _____

City: _____ Mobile Phone: _____

State: _____ Home Phone: _____

Zip Code: _____ Email: _____

Relationship to Patient: _____ Legal Guardian: _____

Same Household: _____ Notify on Admission: _____

Preferred Language: _____ Written Language: _____

Need Interpreter: _____

Maryland Primary Care Physicians

Patient Information Sheet

Patient Name: _____ Date of Birth: _____

General Information

Preferred Language: _____
Written Language: _____
Marital Status: _____
Need Interpreter: _____
Ethnicity: _____
Religion: _____
Veteran Status: _____
Race: _____
Country of Birth: _____

Additional Information

Employer Information:

Employer: _____
Employment Status: _____
Occupation: _____
Employment Date: _____
Employment Address: _____
_____
Employment City: _____
Employment State: _____
Employment Zip: _____
Employment Phone: _____

Additional Information:

Patient Pharmacy Preference:

_____
(Pharmacy Name) (Pharmacy Address) (Pharmacy Number)

_____
(Pharmacy Name) (Pharmacy Address) (Pharmacy Number)

Do you have any Special Needs? (Please list them)

_____

_____

How did you hear about us?

- ☐ Family/Friend
- ☐ MPCP Website
- ☐ Internet
- ☐ Facebook
- ☐ Print Ad
- ☐ Righttime Referral
- ☐ Hospital Referral
- ☐ Insurer Info
- ☐ Other: _____

Maryland Primary Care Physicians

Patient Information Sheet

Patient Name: _____ Date of Birth: _____

Coverage Detail Primary

Insurance Company: _____
Claim Address: _____

Member Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance ID: _____
Member Effective From: _____

Subscriber ID: _____
Group Number: _____

Auth Phone: _____
Name on Card: _____

Subscriber Demographics (If Not Patient)

Name: _____
Address: _____
_____

Date of Birth: _____ Sex: _____
Social Sec. #: _____
Mobile Phone: _____
Home Phone: _____
Email: _____

Subscriber Employment

Employer: _____
Employment Status: _____
Employment Address: _____
_____

Employment Date: _____
Occupation: _____
Phone: _____

Coverage Detail Secondary

Insurance Company: _____
Claim Address: _____

Member Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance ID: _____
Member Effective From: _____

Subscriber ID: _____
Group Number: _____

Auth Phone: _____
Name on Card: _____

Subscriber Demographics (If Not Patient)

Name: _____
Address: _____
_____

Date of Birth: _____ Sex: _____
Social Sec. #: _____
Mobile Phone: _____
Home Phone: _____
Email: _____

Subscriber Employment

Employer: _____
Employment Status: _____
Employment Address: _____
_____

Employment Date: _____
Occupation: _____
Phone: _____

RELEASE: I assign payment to and authorize Maryland Primary Care Physicians, LLC to file a claim with my insurance for payment of services or to accept assignment of any government benefits due to me. I authorize the release of all information necessary to process these claims. I understand that if it is later determined that I am not eligible to receive benefits for these services, I will personally be responsible for payment to Maryland Primary Care Physicians, LLC. Photocopies of this form are valid.

_____ _____

Signature of Patient or Responsible Party if Minor Date