MARYLAND VASCULAR SPECIALISTS
Compassionate. Innovative. Trusted.

PATIENT REGISTRATION INFORMATION

PLEASE DO NOT LEAVE ANY BLANK LINES

Date: _____

Patient's Name: _____ Sex: M F
(Last) (First) (Middle Initial)

Home Address: _____
(Number/Street) (City) (State) (Zip)

Email Address: _____ Mobile Phone: _____ Consent to text? Yes/No

Home Phone: _____ Work/Alternate Phone: _____

Preferred Method of Contact: ___ Home Phone ___ Work Phone ___ Mobile Phone ___ Email

Date of Birth: _____ Age: _____ Social Security Number: _____

Marital Status: S M W D Employment: Student Employed Unemployed Retired

Emergency Contact: _____ Relationship: _____ Phone: _____

Our practice is collecting new demographic data as required by the federal government.
We appreciate your assistance in meeting those new national standards.

Preferred Language: (please check one) ___ English ___ Spanish ___ Other: _____

Race: (please check one)
___ American Indian or Alaska Native ___ Asian ___ Black or African American

___ Native Hawaiian or other Pacific Islander ___ Caucasian/White ___ Refused/Declined

Ethnicity: (please check one) ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Refused/Declined

Please list the doctor's names that pertain to your care:

Referring Doctor: _____ Phone Number: _____

Primary Care Doctor/Internist: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Podiatrist: _____ Phone Number: _____

Nephrologist: _____ Phone Number: _____

Other (please specify): _____ Phone Number: _____

Name of Pharmacy: _____

Pharmacy Address & Phone #: _____

** Please complete other side. **

Patient Acknowledgement/Consent Form/Use & Disclosure of Protected Health Information

I acknowledge that I have received a copy of the Notice of Privacy Practices for Maryland Vascular Specialists. I understand a copy of the Notice will be provided to me should I request a copy.

I authorize the Practice to leave a detailed message regarding my appointments or medical care as described below.

On an answering machine?	Yes	No
On voicemail at home or work?	Yes	No
On a cell phone?	Yes	No
With another person?	Yes	No
Through the mail?	Yes	No

Please list any individuals with whom we can discuss your medical care or financial account.

Name	Relationship	Phone

If you would not like us to discuss your care or account with any one, please check here. _____

How did you hear about us?: ___ Healthcare Provider ___ Self-Referral ___ Friend/Relative
___ MVS Website ___ Hospital ___ Social Media ___ Online Search ___ TV Ad ___ Print Ad ___ Event

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Samer Saiedy, M.D., P.A. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted insurance carrier agreements. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____
(Signature of Patient or Authorized Representative)

Please have your insurance cards and photo ID available for scanning into your chart.

For Office Use Only ~ Portal Access Given: Yes No