MARYLAND VASCULAR SPECIALISTS
Compassionate. Innovative. Trusted.

PATIENT REGISTRATION

Patient's Name: _____ Date: _____

Date of Birth: _____ SSN: _____ Male or Female

Home address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Mobile phone: _____

Work phone: _____ Consent to text: Yes or No

Email address: _____ Would you like join our patient portal: Yes or No

Preferred method of contact: _____

Emergency contact's name: _____ Relationship: _____

Home phone: _____ Mobile phone: _____

Next of Kin: _____ Relationship: _____

Home phone: _____ Mobile phone: _____

Our practice is collecting new demographic data as required by the federal government. We appreciate your assistance in meeting those new national standards. If you decline to answer please check here. ☐

Preferred language: ☐ English ☐ Spanish ☐ Other _____

Race: please check one.

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other ☐ Caucasian/White

Ethnicity: please check one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital status: please circle one. Married Single Divorced Separated Widowed Partner

Insurance Information

Insurance policy holder: Self / Other

IF YOU ARE NOT THE POLICY HOLDER PLEASE FILL OUT BELOW

Name _____ Date of birth _____

Mailing address _____

Zip code _____ City _____ State _____

Primary Insurance	Secondary Insurance
Plan name:	Plan name:
Policy number:	Policy number:
Group number:	Group number:
Medical claim address:	Medical claim address:

How did you hear about us? ☐ Provider Referral ☐ Nursing Home Provider ☐ Facebook ☐ Google Search

☐ TV Ad ☐ Print Ad ☐ Radio Ad ☐ Hospital ☐ Community Event

PLEASE LIST THE DOCTOR'S NAMES BELOW THAT PERTAIN TO YOUR CARE.

Referring doctor: _____ Phone: _____

Primary doctor/ Internist: _____ Phone: _____

Cardiologist: _____ Phone: _____

Podiatrist: _____ Phone: _____

Nephrologist: _____ Phone: _____

Other: _____ Phone: _____

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

I authorize the practice to download medication history from Pharmacy Benefit Managers (PBMs). I authorize the practice to receive and send medical records to Providers with whom I am under their care.

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
Through the mail?	Yes	No
With another person?	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 initial here. _____

I request that payment of authorized Medicare/ Insurance carrier benefits be made on my behalf to Maryland Vascular Specialists/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 THE FRONT DESK.