Georgetown University Hospital
MedStar Health

PATIENT REGISTRATION

GEORGETOWN PHYSICIANS GROUP

Washington, DC 20007

PATIENT

Name *(Last, First, Middle)*: _____ Date of Birth: _____ **Medical Record Number**

Address: _____ Age: _____ Sex: _____

_____ Race: _____

Phone: _____ SSN: _____ M. Status: _____

Employer: _____

Address: _____

Occupation: _____ Phone: _____ Ext: _____

Emergency Contact Name: _____ Next of Kin: _____

Address: _____ Address: _____

_____ _____

Relationship: _____ Phone: _____ Relationship: _____ Phone: _____

PHYSICIAN

Primary Care Physician: _____ Referring Physician: _____

_____ _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

GUARANTOR

Guarantor Name (Bill To): _____ Guarantor's Employer: _____

_____ _____

Address: _____ Address: _____

_____ _____

Phone: _____ SSN: _____ Phone: _____

INSURANCE

PRIMARY CARRIER Name: _____ ***SECONDARY CARRIER*** Name: _____

PRIMARY CARRIER Address: _____ ***SECONDARY CARRIER*** Address: _____

_____ _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Employer: _____ Subscriber's Employer: _____

DOB: _____ SSN: _____ DOB: _____ SSN: _____

ID / Policy #: _____ Group #: _____ ID / Policy #: _____ Group #: _____

Effective Date: _____ Expiration Date: _____ Effective Date: _____ Expiration Date: _____

WORKER'S COMP: If work related injury, please complete this section:

Employer: _____ Injury Date: _____ Case Number: _____

Case Worker / Contact Name / Phone Number: _____

_____

Insurance Carrier Name / Phone Number: _____

Claims Address: _____

_____

See Reverse Side