Registration

Hoffman and Associates OB/GYN

PATIENT REGISTRATION - PLEASE PRINT CLEARLY

Patient Name: First Middle Last		Name You Wish to be Called	Age & Date of Birth
Home Address Apt. No.		City, State & Zip Code	
Occupation	Social Security No.	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered	
Cellular Phone	E-Mail Address		Home Phone
Employer (or previous employer, if retired)	Work Address		Work Phone – ext
Name of Insured and Relationship to You			Insured's Social Security #
Address of Insured Person	Date of Birth of Insured Person		Phone No. of Insured
Name of Spouse (or Parent)	Home Phone		Cellular Phone
Address of Spouse (or Parent)			Work Phone
Emergency Contact	Relationship	Home Phone	Work Phone – ext
Emergency Contact Address			
Primary Care MD	Address		Office Phone

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BALTIMORE
The Mead Building
315 N. Calvert Street
Baltimore, Maryland 21202

BALTIMORE WEST
7001 Johnnycake Road
Suite 105
Windsor Mill, Maryland 21244

BALTIMORE EAST
3601 O'Donnell Street
Suite 150
Baltimore, Maryland 21224

CONTACT
office: 410-633-6300
fax: 410-633-6736
web: hoffmanobgyn.com

Registration *continued*

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COPY OF INSURANCE CARD

Patient Authorization

I certify that the information I have reported with regard to my health insurance coverage is correct and I have read and understand the Insurance and Billing information and patient policies. I authorize the release of any necessary information, including medical information for this and any related claim, to the above named Insurance Company (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration)/Medicare in order to determine benefits to which I may be entitled. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above named carrier or me at any time.

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received information regarding the privacy notice.

Date	Signature of Subscriber or Beneficiary
Date	Signature of Subscriber or Beneficiary
Date	Signature of Subscriber or Beneficiary