DR'S. HECHT, BASS, ROSEN AND SCHWARTZ, P.A.

3941 Ferrara Drive ○ Wheaton, Maryland 20906 ○ (301) 942-5355
15225 Shady Grove Road, Suite 302 ○ Rockville, Maryland 20850 ○ (301) 330-0550

PATIENT REGISTRATION - *Please Print Clearly*

PATIENT NAME First	Middle	Last			DATE OF BIRTH	AGE
HOME ADDRESS	APT. NO.	CITY		STATE	ZIP CODE	
OCCUPATION EMPLOYED ☐ RETIRED ☐ STUDENT: ☐FT ☐PT	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W		SEX	HOME PHONE	
EMPLOYER (or previous employer, if retired)	ADDRESS				WORK PHONE	
SPOUSE (OR PARENT) NAME	SPOUSE (OR PARENT) EMPLOYER				SPOUSE (OR PARENT) WORK PHONE	
SPOUSE (OR PARENT) ADDRESS						
NEAREST RELATIVE / FRIEND	RELATIONSHIP	HOME PHONE			WORK PHONE	
RELATIVE / FRIEND ADDRESS						
REFERRING PHYSICIAN	ADDRESS				TELEPHONE	

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is that payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, or Money Order.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Other (Specify)_____

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above. X_____

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME LAST NAME			RELATIONSHIP TO PATIENT
	HOME ADDRESS		CITY	STATE
	EMPLOYER		WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME	IS THIS THROUGH EMPLOYER ☐ OR INDIVIDUAL ☐	ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

PATIENT AUTHORIZATION

I,_____, hereby authorize Dr's. Hecht, Bass, Rosen and Schwartz, P.A., to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Medicare, and/or _____ (Name of Other Ins Co)

Insurance Company, be made directly to the above-named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (Name of Medigap Carrier) any information needed to determine these benefits payable for related services.

_____ *Date*

_____ *Signature of Subscriber or Beneficiary*

ACCOUNT NUMBER

PLEASE COMPLETE INFORMATION REQUESTED ON THE REVERSE

GENERAL MEDICAL INFORMATION

DESCRIBE CURRENT MEDICAL PROBLEM/REASON FOR TODAY'S VISIT	
PRESENT MEDICINES	ALLERGIES TO MEDICINES
PREVIOUS OR OTHER MEDICAL PROBLEMS	