Registration & Health Questionnaire

Joseph M Porres, M.D., Ph.D

50 W. Edmonston Dr. # 308

Rockville, MD 20852

Name: _____ Date: _____

First Middle Initial last

Gender: M/F Date of Birth ____/_____/_____Social Security _____Status: Single/Married/Other

Address _____ Tel: (Home) (_____) _____

Street City State Zip

Employed by: _____ Tel (Work) (_____) _____

Tel (cell) (_____) _____

Spouse's name: _____

First Middle Initial Last

Spouse's employer: _____ Spouse's work tel: (_____) _____

REFFERING MD: _____ City/State: _____ (UPIN) _____

PERSONAL DOCTOR: _____ City/State: _____ (UPIN) _____

Reason for the visit: _____

Medication allergies	Medication and OCT taken	***For Office use only:***
		Need referral yes/no
		Copay per visit :$
		Yearly deductible $ as of _____/_____/____
		Yearly deductible met yes/no
		Health benefits effective date:____/_____/_____
		Primary insurance:
		Secondary Insurance:

Assignment of Insurance Benefits: I HEREBY AUTHORIZE DIRECT INSURANCE PAYMENT TO DR. JOSEPH PORRES, IF ANY, OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED. I AUTHORIZE RELEASE OF MEDICAL RECORDS TO MY INSURANCE COMPANY. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION

_____ _____

Patient or responsible party's signature Date

Insurance policy holder (if other than patient)

Name: Relationship to patient:

Address if different from patient's

Employer : Work telephone::

Date of birth::__/___/_____ Social security: