University of Medical Center

OUTPATIENT REGISTRATION

FORM NO. 3542 - 2041 (REV 2/01)

PATIENT

PATIENT NAME			PHONE NO.		REG. DATE	REG. TIME	PT. TYPE	PT. AREA/DUE DATE	MEDICAL RECORD NO.		
STREET			APT. NO.	ACCOUNT NO.		MED. SERVICE		BIRTHDATE	AGE	SEX	MAR. STAT.
CITY	STATE	ZIP CODE	COUNTY	RELIGION	CIT. BIRTHPLACE	SSN		PRIOR ADMIT DATE	RACE		
MOTHER'S MAIDEN NAME			FATHER'S NAME				P.O. NUMBER			SPEC. INDICATORS	
ATTENDING PHYSICIAN'S NAME			PHYS CODE	REG BY	INFORMATION GIVEN BY			RELATIONSHIP			

GUARANTOR

GUARANTOR'S NAME			STREET	APT NO.	CITY		STATE
ZIP CODE	PHONE NO.	RELATIONSHIP				NO. OF INS.	FIN CL

EMERGENCY

EMERGENCY CONTACT NAME, ADDRESS, PHONE, RELATIONSHIP		REFERRING PHYSICIAN'S NAME, ADDRESS, PHONE

INSURANCE

INSURANCE NAME CARDHOLDER'S EMPLOYER	POLICY / CLAIM / MEMBER # / GROUP # PLAN CODE	EFFECT. DATE CARDHOLDER'S BIRTHDATE	EXP. DATE	CARDHOLDER'S NAME RELATIONSHIP TO PATIENT

WORKMAN'S COMP. CARRIER	EMPLOYER (WHERE INJURY OCCURRED)	CLAIM NO.

EMPLOYMENT

GUARANTOR EMPLOYER'S NAME, ADDRESS, PHONE, OCCUPATION	PATIENT / SPOUSE EMPLOYER'S NAME, ADDRESS, PHONE, OCCUPATION

CHIEF COMPLAINT / REASON FOR VISIT

REMARKS

CONSENT TO MEDICAL CARE AND TREATMENT: I CONSENT TO HOSPITAL CARE ENCOMPASSING ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT FOR THE PATIENT, FURTHERMORE, IF THE PATIENT IS AN OBSTETRIC PATIENT ADMITTED TO THE HOSPITAL FOR THE DELIVERY OF A BABY, I CONSENT TO HOSPITAL CARE OF THE INFANT(S) ENCOMPASSING ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT. ☐ TELEPHONE CONSENT

INSURANCE CERTIFICATION AND ASSIGNMENT: I HEREBY CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE SIX OF THE SOCIAL SECURITY ACT, BY MY INSURERS, OR BY ANY OTHER THIRD PARTY PAYORS IS CORRECT. I ASSIGN TO THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM ALL HOSPITAL BENEFITS DUE ME UNDER THE TERMS OF SAID POLICIES AND PROGRAMS BUT NOT TO EXCEED THE HOSPITAL'S REGULAR CHARGES FOR SIMILAR SERVICES. I ASSIGN PAYMENT TO THE PHYSICIAN(S) RENDERING MEDICAL SERVICES TO THE PATIENT AND I ASSIGN PAYMENT FOR THE UNPAID CHARGES OF THE PHYSICIAN FOR WHOM THE HOSPITAL IS AUTHORIZED TO BILL IN CONNECTION WITH ITS SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY HEALTH INSURANCE DEDUCTIBLE(S), COINSURANCE, OR ANY OTHER CHARGES INCURRED WHICH ARE NOT PAID BY MY INSURERS OR OTHER THIRD PARTY PAYORS.

MEDICARE AUTHORIZATION: (IF APPLICABLE) I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS TO THE HOSPITAL ON THE PATIENT'S BEHALF FOR ANY SERVICES FURNISHED THE PATIENT BY OR IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM INCLUDING PHYSICIAN SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT THE PATIENT TO RELEASE TO MEDICARE AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES.

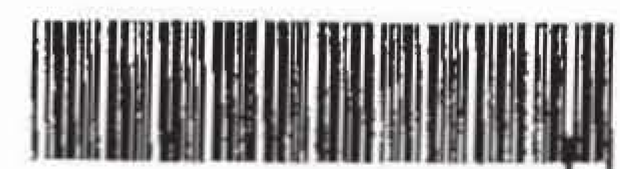
RELEASE OF INFORMATION: I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL PHARMACY, INSURANCE COMPANY, EMPLOYER OR ORGANIZATION TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, OR BENEFITS PAYABLE FOR THIS CLAIM TO ANY ORGANIZATION RESPONSIBLE FOR PAYMENT ON THIS CLAIM OR TO ANY PHYSICIAN OR MEDICAL SERVICE ORGANIZATION WHO WILL RENDER CARE TO THE PATIENT AFTER DISCHARGE FROM THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM.

VALUABLES RELEASE: THE HOSPITAL SHALL NOT BE RESPONSIBLE FOR THE LOSS OF OR DAMAGE TO ANY PERSONAL PROPERTY OF THE PATIENT BROUGHT INTO THE HOSPITAL.

GUARANTEE OF ACCOUNT: I HEREBY ACKNOWLEDGE RESPONSIBILITY FOR THIS ACCOUNT AND ASSUME AND GUARANTEE PAYMENT OF ALL HOSPITAL EXPENSES INCURRED DURING THIS ADMISSION. IN THE EVENT A CREDIT (REFUND) BALANCE APPEARS ON THIS ACCOUNT, I HEREBY IRREVOCABLY AUTHORIZE THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM TO TRANSFER AND APPLY SUCH CREDIT ON ANY OUTSTANDING ACCOUNT AT THE HOSPITAL INCURRED BY MYSELF OR MY DEPENDENTS. SHOULD THIS ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ATTORNEY FEES OF TWENTY-FIVE PERCENT (25%) AND COLLECTION EXPENSE. IT IS UNDERSTOOD THAT ALL JUDGEMENTS IN A COURT OF LAW MAY BEAR INTEREST AT THE LEGAL RATE.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ THE FOREGOING AND IS THE PATIENT OR THE PARENT OR GUARDIAN OF THE PATIENT OR IS DULY AUTHORIZED AS PATIENT'S AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. YOUR SIGNATURE DENOTES THE INFORMATION GIVEN BY THE PATIENT, PARENT, GUARDIAN OR AUTHORIZED AGENT IS ACCURATE TO THE BEST OF YOUR KNOWLEDGE.

PATIENT OR RESPONSIBLE PARTY NAME (PRINTED)	PATIENT OR RESPONSIBLE PARTY NAME (SIGNATURE) (SEAL)	RELATIONSHIP
ADDRESS	WITNESS	REASON IF UNABLE TO SIGN:
CITY / STATE / ZIP CODE	DATE / TIME	☐ MINOR (UNDER 18 YRS.) ☐ PHYSICAL CONDITION ☐ MENTAL CONDITION



MEDICAL RECORDS