LORRAINE OFORI-AWUAH, M.D., P.A.

White Marsh Professional Center
5430 Campbell Blvd, Suite 214
Baltimore, MD 21236
Tel: (410) 933-4970
Fax: (410) 933-4971

New Patient Registration

PLEASE PRINT

Appointment Date / /

PATIENT INFORMATION					
Last Name	First	MI	Date of Birth	Social Security #	Sex
Home Address	City	State	Zip Code	Marital Status	Age
E-mail Address 1				Home Phone	Cell Phone
Pharmacy Name	Pharmacy Phone		Pharmacy Fax		
Employment Status Employed ( ) Full Time Student ( ) N/A (	Employer Name/School Name			Title/Position	
Work Address	City	State	Zip Code	Work Phone	

REFERRING PHYSICIAN INFORMATION				
Last Name	First	MI	Address	Telephone ( )

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION			
Last Name	First Name		MI
Address		State	Zip Code
Home Phone Work Phone		Cell Phone Email Add:	
Relationship Friend ( ) Spouse ( ) Other ( ) Pls Specify			

PRIMARY INSURANCE COMPANY INFORMATION					
Primary Insurance Company Name			Identification Number		Group Number
Address	City	State	Zip Code	Phone	
Policyholder (if other than patient)			Sex	Date of Birth	
Social Security Number of Policyholder	Phone Number of Policy Holder			Relationship to Patient	
Employer of Policyholder					

SECONDARY INSURANCE COMPANY INFORMATION					
Secondary Insurance Company Name			Identification Number		Group Number
Address	City	State	Zip Code	Phone	
Policyholder (if other than patient)			Sex	Date of Birth	
Social Security Number of Policyholder	Phone Number of Policy Holder			Relationship to Patient	
Employer of Policyholder					

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT	
I hereby assign all medical benefits to which I am entitled to the office of Dr. Ofori-Awuah in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes deliquent and is therefore in default of payment. I accept the responsibility for the principal amount owing as well as all reasonable cost associated with the collection of this debt. This includes but is not limited to collection services fees, attorney fees, and all court cost and additional legal fees associated with the recovery of this debt. Interest my be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel at the office of Dr. Ofori-Awuah as my be indicated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence. I acknowledge that I may be charge a no show fee if I fail to give 24 hour notification to cancel an appointment.	
Authorized Signature X	Today's Date