Raja M. Din, M.D.
7501 Greenway Center Drive, Suite 620
Greenbelt, MD 20770 Phone: 301-715-3744 Fax: 301-477-3525

PATIENT INFORMATION

DATE: _____ ☐ **MALE** ☐ **FEMALE**

PATIENT NAME: _____ , _____ _____
Last Name First Name Middle Initial

SSN(required for billing purposes) #: _____/_____/_____ **DOB:** _____/_____/_____
Month Day Year

ADDRESS: _____ **Apt #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

EMAIL: _____ **HOME:** _____ **CELL:** _____

☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED** ☐ **SEPARATED**

RACE: _____ **PREFERRED LANGUAGE:** _____

EMERG. CONTACT NAME: _____ **RELATIONSHIP:**_____**PHONE:** _____

Authorized person to discuss medical records: ☐ Same as emergency contact or _____

PRIMARY CARE DOCTOR: _____ **PHONE #:** _____

PHARMACY NAME: _____**PHARMACY ADDRESS or CITY:** _____

PRIMARY INSURANCE NAME: _____ **SECONDARY INSURANCE NAME:** _____

POLICY HOLDERS NAME:_____ **POLICY HOLDERS NAME:**_____

POLICY HOLDERS D.O.B._____ **POLICY HOLDERS D.O.B.**_____

☐ **I HAVE READ AND UNDERSTAND THE ACKNOWLEDGEMENT of FINANCIAL RESPONSIBILITY**. _____
Initial

☐ **I HAVE READ AND UNDERSTAND THE PATIENT PRIVACY NOTICE**. _____
Initial

☐ I **DO** authorize the medical staff to leave detailed messages on my voicemail or answering machine regarding appointments, lab results, imaging (radiology) results, and other clinical information.

☐ I **DO NOT** authorize the medical staff to leave detailed messages on my voicemail or answering machine regarding appointments, lab results, imaging (radiology) results, and other clinical information.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____
Signature of Patient or Parent/Guardian if minor **Date**