PATIENT REGISTRATION

Capital Medical Associates, P.C.
1640 Rhode Island Avenue, NW, Suite 800
Washington, D.C. 20036
202-822-6311

Bruce S. Rashbaum, M.D.
Theo W. Hodge, M.D.
Mary Beth Alder, Ph.D, CANP
Richard Elion, M.D.

Please Complete Below Each Line

Patients Name: First	Middle	Last	M F	Birth Date	Age

Home/Mailing Address Please Include Apt #	State	Zip

Patients Employer:	Address Address:

Patient Social Security No	Patient Occupation	Financially Responsible Person Patient Sp/part Parent Other	Marital Status M D W P S	Pharmacy Phone

Partner/Spouse's Name	Partner/Spouse's Employer	Employer Address	Work Phone

In Case of Emergency, Contact	Relationship	Phone
In Case of Emergency, Alternate Contact	Relationship	Phone
Referring Physician &/or Person	Address	Phone

Communication Consent

Please Indicate How We May Contact You (Fill-In all that Apply)

Home Phone	Work	Cell	Email
( )	( )	( )	

Subscriber Information or Financially Responsible Party

SUBSCRIBER INSURANCE AND/OR FRP INFORMATION (OTHER THAN SELF)	Subscribers Name:		Subscribers Employer		
	Date of Birth	Relationship to Patient	Social Security No	Work Phone	Home Phone

Subscriber Information or Financially Responsible Party

Secondary Insurance Information

SUBSCRIBER INSURANCE AND/OR FRP INFORMATION (OTHER THAN SELF)	Subscribers Name:		Subscribers Employer		
	Date of Birth	Relationship to Patient	Social Security No	Work Phone	Home Phone

Patient Signature Date

Account Number: