Steven M. Shimoura, M.D., P.A.

TO OUR PATIENTS: PLEASE FILL OUT THIS FORM IN ITS ENTIRETY.

PATIENT REGISTRATION

Patient Name_____ **Social Security#**_____
Street Address_____ **Date of Birth**_____ **Age**_____
City/State/ZIP Code_____ **Home Phone**_____
Employer_____ **Cell Phone**_____
Work Phone_____
Employer Address_____ **Occupation**_____
City/State/ZIP Code_____ **Marital Status**_____ **Sex**_____

RESPONSIBLE PARTY OTHER THAN THE PATIENT IF UNDER 21

Guarantor Name_____ **Social Security #**_____
Street Address_____ **Home Phone**_____
City/State/ZIP Code_____ **Work Phone**_____

INSURANCE INFORMATION
(MUST BE FILLED OUT COMPLETELY)

Primary Ins. Co._____ **Secondary Ins. Co.**_____
Policy Holder Name_____ **Policy Holder Name**_____
Date of Birth_____ **Date of Birth**_____
Subscriber's Employer_____ **Subscriber's Employer**_____
City/State/ZIP Code_____ **City/State/ZIP Code**_____
Occupation_____ **Occupation**_____
Policy Number_____ **Policy Number**_____
Group Number_____ **Group Number**_____

REFERRING DOCTOR_____ **PHONE**_____

PATIENT MEDICAL HISTORY

_____**DIABETES** _____**THYROID DISEASE**
_____**HYPERTENSION** _____**HEART DISEASE**
_____**LIVER DISEASE** _____**ALCOHOL**
_____**ASTHMA** _____**SMOKING**_____**# OF PACKS PER DAY**

OTHER HISTORY:_____

ALLERGIES TO MEDICATIONS:_____

DATE OF INJURY/ONSET OF SYMPTOMS: _____

FEDERAL LAW ACKNOWLEDGES PERSON 18 YEARS OLD TO BE AN ADULT AND, THEREFORE, RESPONSIBLE FOR THEIR OBLIGATIONS. IN THE UNFORTUANTE EVENT COLLECTIONS PROCEDURES ARE REQUIRED TO COLLECT AN OUTSTANDING BALANCE, THE PATIENT SHALL BE RESPONSIBLE FOR THE ADDITIONAL COSTS (100% OF THE PAST DUE BALANCE) OF A COLLECTION AGENCY, ATTORNEY, AND/OR COURT COSTS. UNPAID BALANCES OF 90 DAYS OR MORE WILL BE SENT TO COLLECTIONS.
I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY, AND CERTIFY THAT I AM THE PATIENT, OR DULY AUTHORIZED GENERAL AGENT OF THE PATIENT, AUTHORIZED TO FURNISH THE INFORMATION REQUESTED. I CERTIFY THAT THE INFORMATION I HAVE REPORTED IS CORRECT. I UNDERSTAND THAT EVEN THOUGH I HAVE SOME TYPE OF INSURANCE, I AM RESPONSIBLE FOR UPDATING THE PRACTICE WITH ANY CHANGES TO THE INFORMATION ABOVE.
RELEASE OF INFORMATION/AUTHORIZATION TO FILE: AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS A CLAIM AND HEREBY AUTHORIZE Steven M. Shimoura, M.D., P.A. TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES.

_____ _____
SIGNATURE **DATE**

PLEASE FILL OUT BACKSIDE OF FORM

Steven M. Shimoura, M.D.,P.A.

18111 Prince Phillip Drive
Suite 123
Olney, MD 20832

5999 Harpers Farm Road
Suite W230
Columbia, MD 21044

Contact Information

Please assist us by providing information where we can contact you

Location	May we leave a message?	Phone #
____Home	____Yes ____No	_____
____Office	____Yes ____No	_____
____Cell Phone	____Yes ____No	_____
Other:		
_____	____Yes ____No	_____
_____	____Yes ____No	_____
_____	____Yes ____No	_____

_____

Signature of Patient or Parent/Guardian Date

CURRENT MEDICATIONS (PLEASE INITIAL AND DATE)

_____
_____
_____
_____
_____
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_____
_____
_____
_____