REGISTRATION INFORMATION
INTERNAL MEDICINE

FORD MEDICAL ASSOCIATES, PA
KEVIN M. FORD, MD
KAREN L. BLEDSOE, MD

7404 EXECUTIVE PLACE SUITE 501
LANHAM, MARYLAND 20706
PHONE:(301)262-0260 FAX:(301)262-0630

Date________ Home Phone (____) ________________ Work Phone (_____) ________________ Cell Phone (_____) ___________

Patient: ____
Last Name First M.I

Sex: □ M □ F Age:__________ Birthdate:_______-_______-______ Soc Sec # ____________________

Address:______________________________ City/State:____________________ Zip:______________

Emergency Contact Information

Name:____

Relationship:______________________________ Phone (_____)______________________________

Primary Insurance

Contract Holders:______________________________________ Date of Birth____________________
Last Name First Name M.I.

Relationship to Patient:__________________________ Employer:__________________________

Insurance Company :__________________________ Phone(_____)__________________________

Address__________________________ City, State__________________ Zip__________

Contract Number:__________________________ Group Number__________________________

Effective Date__________________________ Cancellation Date:__________________________

Source of Verification (See Attached Copy)____
(Driver's License, Social Security Card, or Insurance Card)

IF YOU HAVE MORE THAN ONE COMMERCIAL INSURANCE PLEASE SEE THE RECEPTIONIST FOR AN ADDITIONAL FORM.

COMMERCIAL AUTHORIZATION

I certify that to the best of my knowledge the above information is correct. I authorize Dr. Ford and Dr. Bledsoe to review my insurance coverage with my insurance company as indicated above. I authorize any holder of medical information to release medical and other information to my insurance company for review of my coverage and/or for processing of claims for services rendered to me. I further authorize the release to Ford Medical Associates of such information as may be necessary for these purposes by my insurance company.
I hereby authorize you to pay directly to the below named doctor benefits due me out of my indemnity under the terms of my policy issued by your company.

Ford Medical Associates, PA

Payment is authorized upon your receipt of itemized statement for services rendered. Payment of this amount as herein directed, in whole or in part, shall be considered the same as if paid by your company directly to me. I permit a copy of this authorization to be used in place of the original.

Signed____ Date____________________
(If insured is a minor, parent or guardian must sign)

Signature of Person Completing Form__________________________ Date____________________