11315 Pembrooke Square
Suite 110
Waldorf, MD 20603-4806
(301) 645-6165 (301) 843-6996

ROBERT E. MILLER M.D., F.A.A.P., P.A.

PEDIATRIC MEDICINE FOR INFANTS, CHILDREN AND ADOLESCENTS

23000 Moakley Street
Suite 202
Leonardtown, MD 20650-2916
(301) 475-7222 (301) 475-7223

TAX I.D. # 52-1237896

FAMILY REGISTRATION - Please print clearly PATIENT'S INFORMATION

PATIENT NAME FIRST	MIDDLE	LAST	DATE OF BIRTH	SEX

HOME ADDRESS	APT. NO.	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	ALTERNATE PHONE	SOCIAL SECURITY NUMBER

HAVE ANY OF YOUR CHILDREN BEEN SEEN IN THIS OFFICE?

☐ YES ☐ NO List their Names

ANY DRUG ALLERGIES? IF SO, PLEASE LIST.

FATHER / GUARANTOR INFORMATION

FIRST	MI	LAST	SOCIAL SECURITY NUMBER	HOME PHONE

HOME ADDRESS	DATE OF BIRTH	CITY	STATE	ZIP CODE	CELL PHONE

EMPLOYER	ADDRESS	WORK PHONE

MOTHER / GUARANTOR INFORMATION

FIRST	MI	LAST	SOCIAL SECURITY NUMBER	HOME PHONE

HOME ADDRESS	DATE OF BIRTH	CITY	STATE	ZIP CODE	CELL PHONE

EMPLOYER	ADDRESS	WORK PHONE

BILLING INFORMATION

FINANCIALLY RESPONSIBLE PERSON ☐ Patient ☐ Mother ☐ Father ☐ Other: _____	NAME IF DIFFERENT THAN MOTHER OR FATHER	HOME PHONE

FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (IF DIFFERENT THAN PATIENT)

FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER	EMPLOYER ADDRESS	WORK PHONE

INSURANCE INFORMATION

POLICY HOLDER ☐ Self ☐ Father ☐ Mother ☐ Other	PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	

INSURANCE COMPANY ADDRESS	ID/POLICY NO.	GROUP NO.

SECONDARY INSURANCE COMPANY NAME & ADDRESS	SUBSCRIBER'S NAME	ID/POLICY NO.	GROUP NO.

REFERRAL / EMERGENCY INFORMATION

IN CASE OF EMERGENCY, CONTACT (OTHER THAN PARENTS)	RELATIONSHIP	WORK PHONE	HOME PHONE

REFERRED BY: ☐ Another Doctor ☐ Present Patient ☐ Yellow Pages ☐ Other: _____	REFERRAL NAME/ADDRESS

Policy Concerning Payment of Medical Bills

The parent who requests treatment for the child is responsible for all fees for services rendered. The undersigned agrees that professional services are rendered and charged to the patient and not to the insurance company or other third party. I further understand that I am responsible for payment for all medical services at the time the services are rendered.

In the event that the account becomes assigned to a collection agency I agree to pay the 25% collection agency fees associated with my account balance. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

Please sign and date below to acknowledge that you have read and understand this policy.

SIGNATURE DATE (SEAL)

PATIENT ACCOUNT NUMBER _____

cbsi/P0845-PI.indd (9/22/09)

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Information for "Patient's Authorization"

I, _____ , hereby authorize Robert E. Miller, M.D., F.A.A.P., P.A., to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS of the National Capital Area, Blue Shield of MD, Medicare and/or

_____ (other insurance company name) be made directly to the above named Practice (or in case of Medicare Part B benefits, to myself or to the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to BC/BS of the National Capital Area, the above named billed agent, BS of Maryland (or in the case of Medicare Part B benefits, to the Social Security Administration

and Health Care Financing Administration) and/or _____ (other insurance company name). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or above named carrier at any time in writing.

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and subject to the following restriction(s) concerning my personal medical information and I agree to the disclosures named in the notice.

_____

Signature of Subscriber or Beneficiary ID # Date

PATIENT ACCOUNT NUMBER _____