Southern Maryland Associates, LLC

Client Information:

Name:	Email Address:	Phone:
Street Address:	City:	State and Zip:
Cell phone no.:	Home Phone:	Social Security #:
Date of Birth:	Gender:	Employer:

Primary Insurance:

Primary Insurance Company:	Insurance Co. Address:	Insurance Co. City/State/Zip :
Insurance Co. Phone #:	Policy Holder's I.D #:	Plan Name:
Effective Date:	Policy/FECA #:	Group #:
Policy Holder's Employer:	Co-Pay Amount:	Client's Relationship to Policy Holder:
Policy Holder's Name:	Policy Holder's Address:	Policy Holder's City/State/Zip:
Policy Holder's Birth Date:	Policy Holder's Phone #:	Preauthorization Required?:

Financial Responsibility:

Person responsible for bill:	Address (if different):	Phone no.:

If you have Secondary Insurance, please provide that information on page 2.

Emergency Contact Name And Phone #:

I authorize Southern Maryland Associates to file insurance claims, and accept payments on my behalf, for visits to this office. I understand I am responsible for any balance not covered by my insurance.

Signed: X_____ Date:_____