Dr. Nadu A. Tuakli, M.D., M.P.H
10814 Hickory Ridge Road
Columbia, MD 21044

PATIENT REGISTRATION FORM

NAME_____ DATE OF BIRTH_____
First Middle Last SEX: M F
MARITAL STATUS_____ SS #:_____
ADDRESS_____
Street City State Zip
HOME #:_____ WORK#:_____ CELL #:_____

E-MAIL_____ OCCUPATION_____ EMPLOYER_____

Primary Care Physician_____ Do they want a report of your visit? Y N

PRESENT YOU INSURANCE CARD (S) FOR PHOTOCOPY AND COMPLETE BELOW
If no card is available, payment in full is expected.

PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
Company Name_____	Company Name_____
Policyholder: Yourself Y N If No, complete below	Policyholder: Yourself Y N If No, complete below
Policyholder Name:_____	Policyholder Name:_____
Address, if different_____	Address, if different_____
_____	_____
Employer_____	Employer_____
Work #_____ Home #_____	Work #_____ Home #_____
SEX: M F Birthdate:_____	SEX: M F Birthdate:_____
SS #:_____RELATIONSHIP_____	SS #:_____RELATIONSHIP_____

Do we have your permission to:
Leave a message on your answering machine at home? ____yes ____no
Leave a message at your place of employment? ____yes ____no
Discuss your medical condition with any member of your household? ____yes ____no

Pharmacy of choice _____
In case of Emergency, who should be notified?_____

PAYMENT AND INSURANCE AGREEMENT
I attest the above information is correct and will be used for billing purposes. I authorize release of medical information to my insurance company (s), primary care or referring physician and pharmacies. Further, your signature authorizes the Doctor to release medical information necessary to process your insurance claims (if any). If my insurance company does not pay, I understand that I am responsible for my bill. **Charges and co-pays are due at the time of service. A charge of $25.00 may be assessed for a missed appointment. Also, if my account is turned over to a collection agency, I will be responsible for all collection fees incurred.** I authorize Family Medical Care to act as my agent in helping me obtain payment from my insurance company (s). I authorized payment directly to Family Medical Care. A copy of this can be used in place of the original.

Signature_____Date_____

You will be given the opportunity to review our Notice of Privacy Practices. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996. Please initial to confirm this opportunity. _____