HORIZON®
PSYCHIATRY, LLC

839 Bestgate Road
Annapolis, MD 21401
T: 443.889.3312
F: 410.630.8408

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

LAST NAME: FIRST NAME: MIDDLE INITIAL: CHECK ONE ☐MR. ☐MRS. ☐MS.

MARITAL STATUS: ☐SINGLE ☐MAR ☐DIV ☐SEP ☐WID BIRTH DATE: AGE: SEX: ☐MALE ☐FEMALE

STREET ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: MOBILE: SSN:

OCCUPATION: EMPLOYER: EMPLOYER PHONE:

OTHER FAMILY MEMBERS SEEN HERE:

FINANCIAL RESPONSIBILITY (Photo ID To The Receptionist)

NAME OF PERSON FINANCIALLY RESPONSIBLE (If Not The Patient) DRIVER'S LICENSE NUMBER/STATE ISSUED:

STREET ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: MOBILE PHONE: SSN:

OCCUPATION: EMPLOYER: EMPLOYER PHONE:

INSURANCE INFORMATION (Please Give Your Insurance Card To The Receptionist)

SUBSCRIBER NAME: SSN: BIRTH DATE: INSURANCE CARRIER:

RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER GROUP NUMBER: POLICY NUMBER: CO-PAYMENT:

SUBSCRIBER OCCUPATION: EMPLOYER: EMPLOYER PHONE:

STREET ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: MOBILE PHONE: EMAIL:

IN CASE OF EMERGENCY (Friend or Relative Not Living At Same Address):

NAME: RELATIONSHIP TO PATIENT:

HOME PHONE: MOBILE PHONE: WORK PHONE:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I HAVE ACKNOWLEDGED RECEIPT OF A COPY OF HP'S "NOTICE OF PRIVACY POLICIES & PRACTICES".

PATIENT/GUARDIAN SIGNATURE DATE