Simmonds, Martin & Helmbrecht
26005 Ridge Road, Suite 200
Damascus, MD 20872
(301) 414-2300

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-Time ☐ Part-Time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY #	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP #	
ADRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

I hereby authorize Simmonds, Martin & Helmbrecht to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct to be processed. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or my insurance carrier at anytime in writing.

______________________________ ______________________________
SIGNATURE OF PATIENT / GUARDIAN DATE