PRIVIA MEDICAL GROUP

Liberty Pediatrics & Family Medicine, LLC

Thomas Hickey, MD | Faith Frankel, MD | Jennifer Kottra, DO FAAP | Debra Lee, MD | Manuel Datiles, MD | Ashley Guy, MD
Amy Paulino, CRNP | Lori Kropfelder, CRNP | Sherry Dulling, CRNP | Jessica Kovolenko, CRNP

Date: _____

New Patient Registration-Adult

Patient's Name _____ Date of Birth _____

Patient's Address_____ M / F Allergies _____

_____ Phone # _____

Cell # _____ Work # _____ email: _____

Allergies _____

First and Last Names of Family Members if they will be new patients also:

1. _____ M / F DOB _____
   Allergies _____
2. _____ M / F DOB _____
   Allergies _____
3. _____ M / F DOB _____
   Allergies _____
4. _____ M / F DOB _____
   Allergies _____

EMERGENCY CONTACT

Name _____ Relation _____

Home Phone_____ Cell Phone _____

Pharmacy preference _____ Phone number _____

Primary Lab _____

Do you have children at Liberty Pediatrics? Please list names and dates of birth. _____

_____

5963 Exchange Drive, Suite 100
Eldersburg, MD 21784

Telephone:
410-549-0900

Fax:
410-549-6121

Patient Registration Page 2: Insurance Information

Failure to provide complete and correct information may result in the patient being responsible for the FULL amount of the charge.

State insurances require you to choose a primary care physician (PCP). WE VALIDATE INSURANCE COVERAGE FOR EVERY VISIT. IF WE ARE NOT THE PCP ON RECORD, WE WILL NOT BE ABLE TO SEE YOUR CHILDREN UNTIL IT IS CHANGED. You will need to call the insurance to change the PCP and provide our office with a reference number. If you do not change the PCP and our office is not paid, we will not be able to see your family in the future.

Primary Insurance

Name of Insurance Company _____

Address for Claim Submissions _____

Insurance Company Phone Number _____

Policy Holder's Name _____ Policy Holder's Birth Date _____

Employer _____ Membership ID# _____

Group # _____ Effective Date _____

Copay _____

Is this a family policy? _____

Secondary Insurance

Name of Insurance Company _____

Address for Claim Submissions _____

Insurance Company Phone Number _____

Policy Holder's Name _____ Policy Holder's Birth Date _____

Employer _____ Membership ID# _____

Group # _____ Effective Date _____

Copay _____

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