Embrace Primary Care, LLC

2101 Medical Park Drive, Silver Spring MD 20902 | Tel: (301) 802-6493 | Fax: (301) 933-6900

Patient Registration

Date:_____

Last name: _____ First name:_____

DOB:_____ Sex: Female or Male

Home phone: _____ Mobile phone: _____

SSN:_____ Email: _____

Address:_____ Marital status: _____

Zip:_____ Language: _____

City:_____ Race: _____

State:_____ Ethnicity: _____

Initial:

_____ *I have the following medical insurance(s). I understand that I am responsible for all applicable copays and deductibles, and that if my insurance denies my claims, I will become responsible for any outstanding balance.*

Reason for Visit: _____

Pharmacy: _____

Allergies (Medication/Food):

_____

_____

_____

_____

Medication (s) list:

_____

_____

_____

_____

Past medical history/problems (Disease (s):

- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Thyroid Problems
- ❑ High Blood Pressure

2101 Medical Park Drive, Silver Spring MD 20902 | Tel: (301) 802-6493 | Fax: (301) 933-6900

- ❑ Low Blood Pressure
- ❑ Diabetes
- ❑ Arthritis
- ❑ Cancer
- ❑ Asthma/COPD
- ❑ Other:_____

Family History

Diabetes:_____
Cancer:_____
High Cholesterol:_____
High Blood Pressure:_____
Thyroid Problems:_____
Asthma/COPD:_____
Kidney Disease:_____
Anemia: _____
Depression/Anxiety:_____
Liver Problem:_____
Other:_____

Social History

Smoker:
- ❑ Yes
- ❑ No

Alcohol Intake:
- ❑ Yes
- ❑ No

Drug use:
- ❑ Yes
- ❑ No

I have read all policies from Embrace Primary Care, LLC and by signing this form I agree to follow all policies as I have filled out the above information to the best of my knowledge.

Patient's Signature:_____ Date:_____