MD-CNS
Maryland Center for Neurology and Sleep
SANGJIN OH, M.D Robert Reif, M.D.

PATIENT REGISTRATION			
Name:	**DOB:**	**Marital Status: S M W D**	
Street Address:	**City:**	**State:**	**Zip:**
Phone- Home#:	**Work#:**	**Employer:**	
Employer Address:			
SSN#:	**Driver's License#:**	**SEX: Male/Female**	
Spouse's Names:	**Spouse's DOB:**	**Spouse's work#:**	
Spouse's SSN#:	**Spouse's Employer Address:**		
(UNDER 18) Parent/Guardian:			
Emergency Contact:	**Phone#:**	**Relationship:**	
Referring Physician:		**Phone#:**	
Insurance & Billing Information			
Primary Insurance:	**Street Address:**		
City:	**State:**	**Zip:**	**Phone#:**
Name of Insured:	**Relationship:**		
Policy#:	**Group/Plan#:**	**Copay:**	**Deductible:**
Secondary Insurance:	**Street Address:**		
City:	**State:**	**Zip:**	**Phone#:**
Name of Insured:	**Relationship:**		
Policy#:	**Group/Plan#:**	**Copay:**	**Deductible:**

Assignment of Insurance Benefits

I herby authorize direct payment of surgical/medical benefits to Sangjin Oh, MD PA/MD-CNS, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Sangjin Oh, MD PA/MD-CNS, to release any medical or incidental information that may be necessary
for either medical care or in processing for financial benefit, including but not limited to, release of information to Insurance carriers, Workers compensation. I received the HIPPA disclosure information.

MEDICARE * MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request that payment of authorized benefits be made on my behalf. I the patient am ultimately responsible for payment of services rendered. A photocopy of these assignments shall be valid as the original.

SIGNATURE: _____ **DATE:** _____