

**Heritage Harbour Health Group Membership Form**  
**801-5 Compass Way**  
**Annapolis, MD 21401**

**GENERAL INFORMATION**

Name: \_\_\_\_\_ Date of Enrollment: \_\_\_\_\_

Address: \_\_\_\_\_ Annapolis, MD 21401

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Marital Status: M \_\_\_ S \_\_\_ W \_\_\_ D \_\_\_ Male \_\_\_ Female \_\_\_

Do you live alone? \_\_\_ If no, Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you, or someone in your household drive? \_\_\_\_\_

How long have you lived in Heritage Harbour? \_\_\_\_\_

Where did you move here from? \_\_\_\_\_

How did you hear about the Health Group? \_\_\_\_\_

**CONTACT INFORMATION**

Neighbor with a key: Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Annapolis, MD 21401

Nearest Relative: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Long-Term Care: \_\_\_\_\_ Other: \_\_\_\_\_

**MEDICAL INFORMATION**

Medical Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Specialist Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Specialist Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

**PATIENT CONSENT**

I authorize and grant my permission for a duly designated registered nurse of the HERITAGE HARBOUR HEALTH GROUP, INC., to review or discuss my medical records and/or medical condition with my attending physicians, hospital or rehab center nurses and/or discharge planner should I request their intervention on my behalf. I also give my consent for a facsimile of my medical records or doctor's orders should I request their intervention on my behalf.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medication List**

List of Medications: (Please include any Prescription, over-the-counter and supplement medications)

Medication Name	Dosage	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

**FOR HEALTH GROUP USE ONLY:**

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Updated:    \_\_\_\_/\_\_\_\_        \_\_\_\_/\_\_\_\_        \_\_\_\_/\_\_\_\_        \_\_\_\_/\_\_\_\_  
Initials:    \_\_\_\_\_        \_\_\_\_\_        \_\_\_\_\_        \_\_\_\_\_