# Upper Chesapeake Health System

520 Upper Chesapeake Dr
Bel Air, MD 21014

## PATIENT INFORMATION

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

| LOCAL ADDRESS | SECONDARY/BILLING ADDRESS (if Applicable) |
|---|---|
| | |

| CITY, STATE ZIP | HOME PHONE | CITY, STATE ZIP | HOME PHONE |
|---|---|---|---|
| | | | |

| PRIMARY CARE PHYSICIAN | REFERRING PHYSICIAN | CONTACT NAME | CONTACT HOME PHONE |
|---|---|---|---|
| | | | |

| 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 | SECONDARY/BILLING ADDRESS (if Applicable) |
|---|---|
| | |
| CITY, STATE ZIP | CITY, STATE ZIP |
| | |
| HOME PHONE | HOME PHONE |
| | |
| RELATIONSHIP TO PATIENT | |
| | |

## PRIMARY INSURANCE

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

## SECONDARY INSURANCE (if Applicable)

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

I certify/verify that the demographic and insurance information provided above is correct. I authorize insurance payments to be made direct to the practice. I understand if the practice does not participate with my insurance that payment is due in full at time of service. I agree to pay for services which are not covered by the benefits of my insurance plan. I have been given the opportunity to review The Practice's Notice of Privacy Practices. I agree that my medication history may be retrieved from the SureScripts RX network for medication verification. This release will expire one year from the date of my signatire unless I cancel it prior in writing.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____