

Patient Information

Thank you for choosing Calvert Internal Medicine! In order to serve you properly, we need the following information. Please print out this form and bring it with you to your first appointment. Please print or type all answers. All information will be kept confidential.

Date _____

Patient Name _____ Account # _____
First/ M/ Last

Address: _____ City _____ State _____ Zip _____

___ Male ___ Female Home Phone: _____ Work Phone _____ Extension: _____

Patient or Parent's Employer: _____ Address: _____

Date of Birth: _____ SSN: _____ Married ___ Single ___ Other _____

Spouse or Parents Name: _____ Phone: _____

Spouse's Employer: _____ Phone: _____

If patient is a student, name of school/college: _____ City _____ State _____

Person to contact in case of an emergency:

1. _____ Telephone: _____

2. _____ Telephone: _____

Are you here for an Auto accident or Personal Injury? ___(Yes) On the Job Injury? ___(Yes) If yes, and you have an attorney, what is his/her name? _____

Driver's License # _____

Responsible Party

Name of the person responsible for this account: _____ Relationship to Patient: _____

Address (if different than above) _____ Home phone: _____

His/Her Birth Date: _____

Employer: _____ Work phone: _____

Is this person currently a patient with Calvert Internal Medicine? ___ (Yes) ___ (No)

Insurance Information (please let us copy your insurance cards)

Name of insured: _____ Relationship to Patient: _____

Birth Date: _____ SSN: _____ Home Phone: _____ Work Phone: _____

Address (if different from patient): _____

Insurance Co: _____ ID# _____ Group # _____

How much is your copayment? _____ Who is your Primary Care Physician? _____

Do you have any additional or second insurance? ____ (Yes) ____ (No) *If yes, complete the following:*

Name of insured: _____ Relationship to Patient: _____

Birth Date: _____ SSN: _____ Home Phone: _____ Work Phone: _____

Address (if different from patient): _____

Insurance Co: _____ ID# _____ Group # _____

How much is your deductible? _____ How much is your copayment? _____

Assignment and Release: I hereby request that my authorized Medicare or other insurance benefits submitted for payment by Calvert Internal Medicine Group be paid directly to them for services furnished to me or my child. I authorized them to release any information required to process submitted claims to my insurance company or, if applicable, to the Health Care Financing Administration or it's agents. I also agree to be responsible for non-covered services, deductibles, and co-payments.

X _____ Date: _____

Signature of patient (or parent if a minor)

(please detach and keep for your records)

Policy Concerning Payment

We participate with AETNA U.S. Healthcare, Alliance, Blue Choice, CareFirst Blue Shield of Maryland, CareFirst Blue Cross/Blue Shield NCA, Cigna, Freestate Health Plan, Medicare, NCPPO, MDIPA, Optimum Choice, and the PHCS Network.

If we participate with your insurance, we ask you to pay your co-payment and any unpaid balance while you are here. We will ask you to pay this after your visit. If we do not participate with your insurance, you will be required to pay your entire visit charge while you are here. The copy of your encounter form can be attached to your claim form when you submit your insurance claim; please ask if you need a copy.

We accept payment by cash, check, MasterCard, Visa, or American Express. Please ask any questions you may have about your bill or about our financial policies. We are happy to help you.