Upper Chesapeake Health System

520 Upper Chesapeake Dr
Bel Air, MD 21014
(443) 643-3255

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE	
MARITAL STATUS	STUDENT STATUS ☐Full-Time ☐Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	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	CITY, STATE ZIP			SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐Full-time ☐Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	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	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		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 _____