CHESAPEAKE AND WASHINGTON HEART CARE, P.C.
Registration Form - PLEASE PRINT CLEARLY

Patient Name:(First) _____ (M) ___ (Last)_____ DOB:__/__/__

Address: _____ City:_____ State:___ Zip:_____

Home Ph: ( )_____ SS#: ____-____-_____ Sex: M F Marital Status: M-S-D-Sep-W

Patient's Employer: _____ Work Phone#:( )_____

Address: _____ City:_____ State:___ Zip:_____

Occupation: _____ Retired: Yes No

Spouse Name: _____ DOB:__/__/__ SS#: ____-____-_____

Spouse's Employer: _____ Work Phone#:( )_____

Employer's Address: _____ City:_____ State:___ Zip:_____

Occupation: _____ Retired: Yes No

Family Physician: _____ City & State:_____

Physician Ph#: _____

List any allergies: _____

Referred to us by: _____

Emergency contact (other than spouse):

Phone #: _____ Relationship to you: _____

INSURANCE INFORMATION

Primary Coverage:	Secondary Coverage:
Insurance Company:_____	Insurance Company:_____
Insurance Address:_____	Insurance Address:_____
ID#: _____ Group #: _____	ID#: _____ Group #: _____
Subscriber's Name:_____	Subscriber's Name:_____
Relat. to Subscriber: Self Spouse Child	Relat. to Subscriber: Self Spouse Child
Is this: HMO PPO Group Other Copay $____	Is this: HMO PPO Group Other Copay $____

I hereby authorize the Corporation of Chesepeake and Washington Heart Care, PC to apply for benefits on my behalf for services rendered by the office of Terence Bertele, MD and his associates, and request that payments from Medicare, Maryland Medical Assistance, BSBC NCA, BSBS MD and/or any other insurance carrier be made directly to the office of Chesapeake and Washington Heart Care, PC. I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any necessary information, including medical information, for this or any related claim to the above named billing agent(s), Medicare, BSBC NCA,BSBC MD, or any Insurance carrier. I permit a copy of this authorization to be used in place of the original.

Date: _____ Patient Signature: _____