STEPHEN F. CALDERON MD PC
TRACY B. BYLAN PA
860-522-7121

DATE ______________________

FIRST NAME ______ M.I. ______ LAST NAME ______ MAIDEN ______ DOB ______

ADDRESS ______________________

ADDRESS ______________________

HOME PHONE ______ WORK PHONE ______ CELL PHONE ______

NAME OF REFERRING PHYSICIAN ______________________

NAME OF EMPLOYER ______ PHONE # ______

INSURANCE

PRIMARY INSURANCE ______________________

ADDRESS ______________________

ADDRESS ______________________

POLICY # ______ GROUP # ______ DOB ______

PATIENTS RELATIONSHIP TO PRIMARY INSURANCE ______________________

SECONDARY INSURANCE

ADDRESS ______________________

ADDRESS ______________________

POLICY # ______ GROUP # ______ DOB ______

PATIENTS RELATIONSHIP TO SECONDARY INSURANCE ______________________

PHARMACY INFORMATION

Pharmacy Name/Address ______ **Phone #** ______

WORKER'S COMP / AUTO INSURANCE INFORMATION

Were you injured on the job? YES / NO

Auto Accident? YES / NO

Date of Injury/Accident

Work Comp / Auto Insurance

Claim #

Address

Address

Claim Adjuster ______ Phone # ______

Employer when injured

BENEFICIARY/GUARANTOR: I request that payment of authorized insurance, Medicaid and Medicare benefits be made on my dependent's behalf to Stephen F. Calderon, P.C. for services rendered to me by a physician. I authorize any holder of medical information about me or my dependent to release to the Center for Medicare and Medicaid Services and its agents or my insurance company any information needed to determine benefits payable including HIV/AIDs, substance abuse, and/or mental health information for related services. I further agree to make payment for any and all service not paid for by my health insurance plan to include, but not limited to, office visit copays, and all deductible amounts stipulated in my contract agreement with my health insurance plan. I have been provided an opportunity to review the HIPAA Notice of Privacy.

Signature ______ **Date** ______