Calin V. Pop, M.D.

Board Certified, Internal Medicine
Patient Intake Form

PLEASE COMPLETE ALL INFORMATION AS IT MAY BE HELPFULIN AN EMERGENCY
IT IS IMPORTANT TO INCLUDE ALL TELEPHONE NUMBERS YOU HAVE

PATIENT INFORMATION

BILLING ACCT#_________________________________ **SOCIAL SECURITY#**_____________________________________
(FOR OFFICE USE ONLY)
FIRST NAME: ____________________ **MIDDLE INITIAL** ___ **LAST NAME** _______________________________________
ADDRESS: ____
CITY ________________________________ **STATE** ________________ **ZIP CODE** _________________________
TEL # ____ **CELL #** ____
EMAIL ___________________________________ **ALTERNATE TEL #** ____
SOCIAL SECURITY # __________________________________ **DOB** ____
SEX: MALE ______ **FEMALE** ______ **MARITAL STATUS** ____
EMERGENCY CONTACT NAME: ____
EMERGENCY CONTACT TEL # ____
EMPLOYER NAME: ___________________________________ **TEL #** ____
SPOUSE'S NAME: ________________________________ **DAYTIME TEL #** ____
NAME OF NEAREST RELATIVE NOT LIVING WITH YOU ____
RELATIVE TEL # ____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:____
INSURANCE COMPANY TEL # ____
POLICY # _____________________________________ **GROUP #** ____
PRIMARY INSURED'S NAME ____
RELATIONSHIP OF PRIMARY INSURED TO PATIENT ____
EFFECTIVE DATE OF POLICY _________________________ **DEDUCTIBLE AMT** __________________________________
PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST TO COPY

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:____
INSURANCE COMPANY TEL # ____
POLICY # _____________________________________ **GROUP #** ____
PRIMARY INSURED'S NAME ____
RELATIONSHIP OF PRIMARY INSURED TO PATIENT ____
EFFECTIVE DATE OF POLICY _________________________ **DEDUCTIBLE AMT** __________________________________

PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST TO COPY
IMPORTANT NOTE
Secondary insurance is filed only if your primary insurance is Medicare

GUARANTOR INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT, OTHER THAN INS.

FIRST NAME ________________ **MIDDLE INITIAL** ____ **LAST NAME** ________________
ADDRESS: ________________
CITY: ________________ **STATE** ________________ **ZIP CODE** ________________
HOME TEL ________________ **WORK TEL** ________________
SOCIAL SECURITY NUMBER ________________ **DOB** ________________
SEX: MALE ______ **FEMALE** ______

PREVIOUS PHYSICIAN

NAME OF PREVIOUS PHYSICIAN ________________
ADDRESS OF PREVIOUS PHYSICIAN ________________
____
TEL # OF PREVIOUS PHYSICIAN ________________

WHOM MAY WE THANK FOR YOUR REFFERAL

NAME ________________ **TEL #** ________________
ADDRESS: ________________

PLEASE READ THE BELOW STATEMENT CAREFULLY, THEN SIGN

My signature below indicates my consent to any and all of the medical services provided to me by the office of Dr. Calin V. Pop. I agree that I am financially responsible for all charges, regardless of my insurance status, and that this office will file my insurance as a courtesy only. Further, I authorize the release of any medical information necessary for my care or financial concerns. I understand and agree that should I have a scheduled appointment and I am not able to cancel within less than 24 hours of said appointment, I will be billed and agree to pay a "No Show" charge of $ 25.00, which will not be billed to my insurance. Lastly, I agree that my signature below give permission for my insurance company to send payment directly to the office of Calin V. Pop, M.D.

MY SIGNATURE BELOW INDICATES MY UNDERSTANDING, AGREEMENT AND ACCEPTANCE OF THE ABOVE TERMS AND CONDITIONS.

________________ ________________

PATIENT'S SIGNATURE DATE

For office use: PS to receive copy of front and back of this form and copy of front and back of all insurance cards.

06/17/06