CARDIOVASCULAR CONSULTANTS, P.C.

PLEASE PRINT

PATIENT INFORMATION

Please bring with you Picture ID, Insurance cards & Medication List

Patient Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Alternate Phone # _____

Social Security # _____ Birth Date _____ Gender _____ Marital Status _____

Email Address _____ Referred by _____

Race (circle one) White / American Indian / Asian / Black or African American / Other

Ethnicity (circle one) Hispanic or Latino / Not Hispanic or Latino

Language _____

How did you hear about us? _____

Employer's Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Family Doctor _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Pharmacy Name _____ Phone # _____ Local or Mail Order _____

Address or Main Cross Roads _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Phone # _____

GUARANTOR INFORMATION (if different than above)

Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Gender _____ Relationship _____

Primary Insurance _____ Claims Address _____

Subscriber Name _____ City _____ State _____ Zip _____

Insurance ID _____ Group # _____ Subscriber SS# _____ Birthdate _____

Secondary Insurance _____ Claims Address _____

Subscriber Name _____ City _____ State _____ Zip _____

Insurance ID _____ Group # _____ Subscriber SS # _____ Birthdate _____

AUTHORIZATION TO PAY BENEFITS: I HEREBY ATHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CARDIOVASCULAR CONSULTANTS, P.C., REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO MY INSURANCE CARRIERS.

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE CARDIOVASCULAR CONSULTANTS, P.C., TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE _____