Cardiology Wellness Center: Patient Information

NAME: _____ _____ _____
(Last) (First) (Middle)

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Social Security Number: _____
Phone: ☐Home _____ ☐Mobile: _____ ☐Work: _____ ☐Other: _____
Email Address: _____

Marital Status: ☐Married, ☐Single, ☐Widowed, ☐Separated Gender: ☐Male, ☐Female

Employer: _____ Employer's Phone: _____
Employer's Address: _____

IN CASE OF EMERGENCY:

Contact Name(s): _____ Relationship: _____
Phone: ☐Home _____ ☐Mobile: _____ ☐Other: _____

REFERRAL INFORMATION:

How were you referred to this office? ☐Family Doctor ☐Emergency Room ☐Friend/ Family ☐Phone book
☐Other: _____ If referred by a doctor, please provide the following information:
Name: _____ ☐M.D. / ☐D.O. Phone:_____
Address: _____

INSURANCE INFORMATION AND FINANCIAL STATEMENT

Do you currently have medical insurance?

⇨ If ☐Yes. [Please have available insurance card or information at time of visit.]

Primary Insurance: _____ Policy Identification Number(s): _____
Claims Address: _____
Secondary Insurance: _____ Policy Identification Number(s): _____
Claims Address: _____

If policyholder is someone other than you, please fill out the following:
Policy Holder's Name _____ Social Security Number: _____
Employer Information: _____

⇨ If ☐ No, I understand payment in full is expected at the time of service, unless other arrangements are made.

I Agree To Pay Any Copay Due At The Time Services Are Rendered. In The Event All Or Part Of The Doctor's Services Are Not Covered By My Insurance Carrier, I Agree To Be Responsible For Any Outstanding Charges On My Account.

To My Insurance Carrier(S): I Authorize The Release Of Any Medical Information Necessary To Process My Insurance Claims(S). I Authorize And Request Payment Of Medical Benefits Directly To My Physicians. I Agree That This Authorization Will Cover All Medical Services Rendered Until I Revoke Such Authorization. I Agree That A Photocopy Of This Form May Be Used In Lieu Of The Original.

SIGNATURE: _____DATE: _____