

**CARDIOVASCULAR CONSULTANTS HEART CENTER**

## PATIENT INFORMATION SHEET

<b>NAME:</b>				<b>SS #</b>	
<b>ADDRESS:</b>				<b>HOME:</b>	
<b>CITY:</b>		<b>STATE:</b>		<b>ZIP:</b>	
<b>CELL:</b>		<b>WORK:</b>			
<b>DOB:</b>	<b>FEMALE / MALE</b>	<b>MARRIED: Y / N</b>	<b>SPOUSE:</b>		<b>WORK:</b>
<b>IF A CHILD, PARENT'S NAME:</b>				<b>THE BEST TIME TO REACH ME IS AT:</b>	
<b>RACE:</b>		<b>ETHNICITY:</b>		<b>LANGUAGE:</b>	
I PREFER TO BE CONTACTED BY: <input type="checkbox"/> HOME PHONE <input type="checkbox"/> CELL PHONE <input type="checkbox"/> MAIL <input type="checkbox"/> <b>PATIENT PORTAL (SECURE E-MAIL)</b>					
<b>E-MAIL ADDRESS FOR PATIENT PORTAL: (PRINT CLEARLY)</b>					
<b>WHO REFERRED YOU TO OUR OFFICE?</b>					
<b>NAME OF FAMILY PHYSICIAN:</b>					
<b>EMPLOYER (OR PARENT'S IF A MINOR)</b>	<b>COMPANY</b>		<b>OCCUPATION</b>		<b>HOW LONG?</b>
	<b>ADDRESS:</b>				<b>PHONE:</b>
<b>SPOUSE'S EMPLOYER</b>	<b>COMPANY</b>		<b>OCCUPATION</b>		<b>HOW LONG?</b>
	<b>ADDRESS:</b>				<b>PHONE:</b>
<b>SPOUSE SS#:</b>				<b>SPOUSE DOB:</b>	
<b>EMERGENCY CONTACT:</b>				<b>RELATIONSHIP</b>	
<b>ADDRESS:</b>				<b>PHONE:</b>	
<input type="checkbox"/> <b>PRIMARY INSURANCE</b>	<b>INSURANCE NAME:</b>				
	<b>INSURED / SUBSCRIBER'S NAME:</b>				
	<b>ID#:</b>		<b>GROUP / PLAN / POLICY #:</b>		
<input type="checkbox"/> <b>SECONDARY INSURANCE</b>	<b>INSURANCE NAME:</b>				
	<b>INSURED / SUBSCRIBER'S NAME:</b>				
	<b>ID#:</b>		<b>GROUP / PLAN / POLICY #:</b>		
<input type="checkbox"/> <b>WORKERS' COMP INFO</b>	<b>COMPANY NAME:</b>				
	<b>SUPERVISOR NAME:</b>				
	<b>COMPANY PHONE:</b>			<b>SUPERVISOR PHONE:</b>	
<b>ATTENTION ALL HMO PATIENTS: I AM AWARE THAT IF CARDIOVASCULAR CONSULTANTS DOES NOT RECEIVE A REFERRAL FROM MY PRIMARY DOCTOR, ALL CHARGES WILL BE MY RESPONSIBILITY.</b>					
I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CARDIOVASCULAR CONSULTANTS HEART CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES NOT COVERED BY MY INSURANCE COMPANY, WHICH INCLUDES MY ANNUAL DEDUCTABLE.					
<b>DATE</b>		<b>PATIENT OR PARENT SIGNATURE</b>			
<b>OFFICE USE ONLY</b>		<b>ACCOUNT NUMBER</b>		<b>REGISTRAR</b>	