

COMPREHENSIVE CARDIOLOGY CONSULTANTS
PATIENT INFORMATION FORM

Patient Name: _____ D.O.B. _____ Sex: M ___ F ___

Street: _____ Apt.#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ S.S.#: _____ Marital Status: _____

Occupation: _____ Employer _____

Work Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____

Spouse/Guardian Name: _____ D.O.B. _____ S.S.#: _____

Address (if different) _____

Spouse/Guardian Employer: _____

Spouse/Guardian's Work Address: _____

Name of Contact Person Other Than Spouse: _____

Relationship: _____ Home #: _____ Work #: _____

Referred By: _____

Family or Primary Care Physician (PCP) _____

Explain the reason for today's office visit: _____

INSURANCE INFORMATION

PRIMARY Insurance: _____

Policy Holder's Name: _____ D.O.B. _____

Patient's Relationship to Policy Holder (Circle one): SELF SPOUSE CHILD OTHER

SECONDARY Insurance: _____

Policy Holder's Name: _____ D.O.B. _____

Patient's Relationship to Policy Holder (Circle one): SELF SPOUSE CHILD OTHER

Health Information Disclosure Authorization: Please circle those family members to whom our Physicians and Staff may disclose/discuss your medical records/test results:

NONE SPOUSE CHILDREN PARENTS OTHER

Please list names here: _____

Medical Benefits Payment Authorization: I authorize payment of medical benefits to Comprehensive Cardiology Consultants for the amount due on any pending claim for services rendered. Yes ___ NO ___

Signature _____ **Date:** _____

Please see reverse side for HIPAA Privacy Notice Authorization Form