COMPREHENSIVE CARDIOLOGY

St. Mary Physicians Group

PATIENT INFORMATION FORM

PATIENT NAME:_____DOB:_____

STREET_____APT#:_____

CITY_____STATE_____ZIP_____

SEX: M_____ F_____ MARITAL STATUS:_____ S.S#:_____

E-MAIL ADDRESS:_____

HOME PHONE #:_____CELL PHONE #: _____

WHICH NUMBER WOULD YOU LIKE US TO USE AS YOUR PRIMARY CONTACT: HOME CELL WORK

OCCUPATION:_____WORK PHONE #:_____

EMPLOYER:_____

RACE:
- **___AMERICAN INDIAN OR ALASKA NATIVE**
- **___ASIAN**
- **___AFRICAN AMERICAN OR BLACK**
- **___NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**
- **___WHITE**
- **___ DECLINE TO ANSWER**

ETHNICITY:
- **___HISPANIC**
- **___NON-HISPANIC**
- **___DECLINE TO ANSWER**

LANGUAGE: _____

SPOUSE/GUARDIAN NAME:_____

NAME OF CONTACT PERSON OTHER THAN SPOUSE:_____

RELATIONSHIP:_____PHONE #:_____

REFERRED BY:_____

FAMILY/PRIMARY CARE PHYSICIAN (PCP):_____

PHARMACY NAME: _____PHONE:_____

PHARMACY ADDRESS:_____

PRIMARY INSURANCE:_____

POLICY HOLDER'S NAME:_____DOB:_____

PATIENT'S RELATIONSHIP TO POLICY HOLDER (circle one): SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE:_____

POLICY HOLDER'S NAME:_____DOB:_____

PATIENT'S RELATIONSHIP TO POLICY HOLDER (circle one): SELF SPOUSE CHILD OTHER

CONSENT: I request and authorize Health Care Services by my physician and his/her designees as may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration. A chaperone will be available for any exam by request, and may be refused at my discretion. YES_____NO_____

MEDICAL BENEFITS PAYMENT AUTHORIZATION: I authorize payment of medical benefits to Langhorne Physician Services for the amount due on any pending claim for services rendered. YES_____NO_____

SIGNATURE:_____DATE:_____