Cardiovascular Associates, P.C.

CARDIAC, THORACIC & VASCULAR SURGERY

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Patient Chart #:_____ Date of Birth:_____

Patient Name: _____ Sex:_____

Address:_____ SSN:_____

City: _____ State:_____ ZIP:_____

Home Phone: _____ Spouse Name:_____ DOB:_____

Alternate #:_____ Spouse Employer:_____

Employer:_____ Spouse Employer Phone #:_____

Employer Phone #:_____ Emergency Contact Besides Spouse:_____

Referring Physician:_____ Emergency Contact Telephone #:_____

Cardiologist:_____ Family Physician:_____

Insurance Information

Insurance:_____
Insured Name:_____
DOB:_____
Contract Number:_____
Group Number:_____

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My office copay is $_____. All copays are due for today's office visit.

Permission for release of Medical Records, Assignment of Benefits, and Acceptance of Financial Responsibility

I authorize direct payment to Cardiovascular Associates, the basic and/or major medical benefits, but not to exceed the balance due of the physician's regular charges for these services. I understand that I am responsible for all charges incurred. I agree to pay any and all fees left unpaid by my insurance company. I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient's Signature:_____ Date:_____