CARDIOLOGY CONSULTANTS, PC

___ William A Hill, Jr., M.D.
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___ John A. Mantle, M.D.
___ L. Anne Lewis, M.D.
___ J. Bradley Proctor, M.D.
___ Gregory Hamrick, C.R.N.P.
___ Caleb Elmore, C.R.N.P.

PATIENT INFORMATION

DATE: ______________________ **ACCT. NUMBER:** ___________

Patient Name____
(First) (Middle) (Last)

Date of birth: _____________________________ **Age:** ______________ **Marital Status: Married/Single**
(Circle)

Mailing Address: ____
(Street) (City) (State) (Zip Code)

Phone Numbers: Home: _____________________ **Cell:** ______________________ **Work:** _______________________

E-mail: ____ **Male or Female** **Social Security No:** ________________

Did another physician refer you here? Y / N **Referring physician:** ____

Who is your family physician? ____

Language: English / Spanish / Other **Race:** _______________________ **Ethnicity: Nonhispanic / Hispanic**
(Circle)

Employed: Y / N / Retired **Employer:** ____________________________ **Phone:** _______________________

Spouse's Name: _________________________**Spouse's Employer:** ________________________ **Phone:** _____________

INSURANCE INFORMATION

Primary Insurance Name: ______________________________________**Effective date:** _____________________
Contract Number: _______________________________________ **Group Number:** __________________________
Insured Name: ____**Insured's Date of Birth:** __________________
Employer Plan? Y / N **Employer:** ____
Patient's relation to insured party: Self / Spouse / Parent / Child / Other **Male / Female**

Secondary Insurance Name: ______________________________________ **Effective date:** ____________________
Contract Number: _______________________________________ **Group Number:** ___________________________
Insured Name: ____ **Insured Date of Birth:** ______________________
Employer Plan? Y / N **Employer:** ____
Patient's relation to insured party: Self / Spouse / Parent / Child / Other **Male / Female**

PLEASE HAVE YOUR DRIVER'S LICENSE AND ALL INSURANCE CARDS AVAILABLE FOR US TO SCAN. THANK YOU.

What is an alternate contact name and number of a person not living with you?
Name: ____ **Phone:** ________________________ **Relation:** ___________

INSURANCE AUTHORIZATION

I hereby authorize Cardiology Consultants, P.C. to release any medical information needed by my insurance carriers in order to process my claim. I hereby authorize payments direct to Cardiology Consultants, PC. I understand that it is my responsibility to provide correct insurance information to Cardiology Consultants, P.C. I understand that my insurance may not pay the bill and that some of the services may be considered "noncovered" by my insurance contract. I understand that I will be responsible for the balance of my account. In the event of a returned check, I understand that a $25.00 fee will be charged to my account at Cardiology Consultants, P.C.

_________________________________ **Date** __________ _________________________________ **Date**__________
Patient's Signature (Agreement to Pay) **Guarantor's Signature (Agreement to Pay)**