CARDIOLOGY CONSULTANTS, PC

___ William A Hill, Jr., M.D.
___ Jeffrey K. Anderson, M.D.
___ Amit K. Shah, M.D.
___ Edward A. Carraway, M.D.

___ 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)**

Revised 05/10/17