CARDIOLOGY CONSULTANTS, PC

___ Jeffrey K. Anderson, M.D.
___ Edward A. Carraway, M.D.
___ Vishal J. Dahya, M.D.
___ Caleb Elmore, C.R.N.P
___ Gregory Hamrick, C.R.N.P.
___ William A. Hill, M.D.

___L. Anne Lewis, M.D.
___ Mike Morgan, C.R.N.P.
___ J. Bradley Proctor, M.D.
___ Amit K. Shah, M.D.
___ Justin Sisk, C.R.N.P.

PATIENT INFORMATION

DATE: _____ **ACCT. NUMBER: _____**

Patient Name_____ Date of Birth:_____Age:_____
(First) (Middle) (Last)

Marital Status: (circle one)
- Married
- Single
- Divorced
- Widowed
- Other

Gender Identity: (circle one)
- Male
- Female
- Female to Male
- Male to Female
- Choose not to disclose

Sexual Orientation: (circle one)
- Lesbian, gay, or homosexual
- Straight or heterosexual
- Bisexual
- Choose not to disclose

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

Phone Numbers: Home: _____ Cell: _____ Work: _____

E-mail: _____ Social Security No: _____

Referring Physician: _____ Primary Care 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 $10.00 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)