

CARDIOLOGY CONSULTANTS, PC

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___ Gregory Hamrick, C.R.N.P.
___ William A. Hill, M.D.

___ L. Anne Lewis, M.D.
___ Petra S. Lynch, 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.

Patient's Signature (Agreement to Pay) Date _____ Date _____

Guarantor's Signature (Agreement to Pay)