

CARDIOLOGY ASSOCIATES

New Patient Information

Welcome to our office. Please help us by furnishing the information requested below to be kept in your chart. It is our policy that we allow the patient to handle filing their own insurance for office visits unless prior arrangements have been made or you belong to a PPO or HMO for which we are providers. All HMO patients MUST HAVE REFERRALS. We do accept Medicare and your supplemental insurance.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Local address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Permanent address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_

Spouse or nearest relative and their phone number \_\_\_\_\_

Pertinent allergies \_\_\_\_\_

Family physician \_\_\_\_\_ Referred by \_\_\_\_\_

Was condition due to employment? \_\_\_\_\_ auto accident? \_\_\_\_\_

Date of injury \_\_\_\_\_

Are you employed? \_\_\_\_\_ If not, retirement date \_\_\_\_\_

Patient's employer \_\_\_\_\_

Employer's address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's employer \_\_\_\_\_

Spouse's employer's address \_\_\_\_\_ Phone \_\_\_\_\_

Do you have Medicare \_\_\_\_\_ *if no, please go to private insurance info below.*

Medicare number, including end letter \_\_\_\_\_

Please provide supplemental insurance name, address and policy number \_\_\_\_\_

\_\_\_\_\_  
If you are not the subscriber on the supplemental policy, please list the subscriber's name, social security number and date of birth \_\_\_\_\_

PRIVATE INSURANCE INFORMATION: Name of insurance, address, and policy number

\_\_\_\_\_  
If you are not the subscriber on the policy, please list the subscriber's name, social security number and date of birth \_\_\_\_\_

CARDIOLOGY ASSOCIATES  
Lifetime Authorization

Medicare Certification For Payment

I certify that the information given by me in applying for payment under the title xvii of the social security act is correct. I authorize any holder of medical or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to medicare for payment to me.

I request that this authorization also apply to all other insurance.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Title Or Relationship \_\_\_\_\_

If signed by other than patient, please state the reason the patient was unable to sign.

\_\_\_\_\_

Insurance Carriers Certification For Payment

I authorize the release of any medical or other information necessary to process any medical claim. I also request payment of medical benefits either to the provider who accepts assignment or to myself.

Signed \_\_\_\_\_ date \_\_\_\_\_

Title Or Relationship \_\_\_\_\_

If signed by other than patient, please state the reason the patient was unable to sign

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