

Doctor: _____

PATIENT INFORMATION

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Best Number to Reach you: Home Cell

Patient ID#: _____ Sex: M F
Date of Birth: _____ Age: _____
Email Address: _____
Social Security #: _____
Marital Status: Married Single Divorced Widowed
Referring Physician: _____
Primary Physician: _____

PATIENT EMPLOYMENT INFORMATION

Employed Retired Unemployed Self-Employed
Employer's Name: _____
Work Phone: _____

EMERGENCY CONTACT

Name	Relationship	Phone
_____	_____	_____
Address: _____		

Person Responsible for Paying the Bill if Other Than Yourself

Name: _____
Address: _____
City, State, Zip: _____

Employer: _____
Home Phone: _____
Work Phone: _____
SS#: _____ Date of Birth: _____

PRIMARY INSURANCE

Office Use Only NA

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Office Use Only NA

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's Date of Birth: _____

INJURY Is this a Motor Vehicle Accident (MVA) or Job Related? Yes No

Spouse Employment: Employed Retired Unemployed Self-Employed

Spouse's Name: _____ Spouse's DOB: _____ Spouse's SS#: _____
Spouse's Employer: _____ Employer's Phone #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or Columbia Cardiology Associates, and authorize Columbia Cardiology to furnish information regarding my illness to my insurance carrier. I have been informed of HIPAA Patient Privacy Rules.

I understand that I am financially responsible for any amount(s) not paid by my insurance company. I acknowledge receipt of the HIPAA privacy policy.

05/18/07 Checked in by: _____

Entered by: _____