

West Side Cardiology Associates

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ Middle Name _____
Date of Birth: ___/___/___ Sex: ___ F ___ M SSN: _____ Race: _____
month/day/year (Please circle) Amer.Indian Asian Black
White Other Declined

Marital Status: Divorced Married Separated Single (please circle) Driver's License: _____ Primary Language: _____ Religion: _____
Widow

Ethnicity: Hispanic or Latino: (please circle) Yes ___ No ___ Declined ___ Prefix: Mr. ___ Mrs. ___ Ms. ___ Miss ___ Dr. ___

Address: Line 1: _____ Line2: _____
City, State, Zip _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____ Primary Phone: _____
Fax: _____ email: _____ Preferred Communications: Phone ___ Fax ___ email ___ Mail ___

Employer Name: _____ Occupation: _____
Address: Line 1: _____ Line2: _____
City, State, Zip _____

Emergency Contact: _____ Relationship _____ Emergency Contact Phone: _____

Whom may we thank for referring you? _____

Primary care physician: _____ Phone: _____
City, State, Zip: _____

INSURED'S INFORMATION

Is Patient the Policy holder? Yes ___ No ___ If the patient is not the policy holder, please complete the following:

Insured's Full Name: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Sex: F ___ M ___
month/day/year

Insured's Address: _____
City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Insured's Employer: _____ Occupation: _____

Employer Address: _____ Telephone: _____
City, State, Zip: _____

PLEASE GIVE YOUR INSURANCE CARD(S) TO OUR REGISTRATION DESK TO BE PHOTOCOPIED

PRIMARY INSURANCE INFORMATION

Policy holder: Same as patient ___ Same as insured ___

Policy ID: _____ Group # _____

Name of Insurance company: _____ Effective date: _____

Phone: _____

Address: _____ City,State,Zip: _____

SECONDARY INSURANCE INFORMATION

Policy holder: Same as patient ___ Same as insured ___

Policy ID: _____ Group # _____

Name of Insurance company: _____ Effective date: _____

Phone: _____

Address: _____ City,State,Zip: _____

TERTIARY INSURANCE

Policy holder: Same as patient ___ Same as insured ___

Policy ID: _____ Group # _____

Name of Insurance company: _____ Effective date: _____

Phone: _____

Address: _____ City,State,Zip: _____

ASSIGNMENT AND RELEASE

I hereby authorize direct payment to West Side Cardiology Associates for services provided. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I agree to pay any and all co-payments and non-covered services at the time services are provided.

I hereby authorize the release of any medical information required for the purpose of obtaining payment for services and determining insurance benefits payable for related services during the course of my treatment.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Printed Name of Patient, Parent, Guardian or Personal Representative