

# West Side Cardiology Associates

## PATIENT INFORMATION

Patient's Full Name:

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: Female \_\_\_ Male \_\_\_  
month/day/year

Marital Status: \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single \_\_\_ Minor

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer/ School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Whom may we contact in case of an emergency?

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Whom may we thank for referring you?

Name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Primary care physician:

Name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Are you here for preoperative clearance? \_\_\_ Yes \_\_\_ No

If you answered "yes", what type of surgery will you be having? \_\_\_\_\_

What date is your surgery scheduled for? \_\_\_\_\_

**Please note that you must notify our office immediately if your surgery date changes during the course of your cardiology work-up.**

## GUARANTOR INFORMATION

Same as patient: \_\_\_ Yes \_\_\_ No If the patient is not the guarantor, please complete the following:

Guarantor's Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: \_\_\_ Female \_\_\_ Male  
month/day/year

Guarantor's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Guarantor'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 guarantor

Policy ID: \_\_\_\_\_ Group # \_\_\_\_\_

Group Name: \_\_\_\_\_ Effective date of insurance: \_\_\_\_\_

Name of Insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ What is your copay for an office visit? \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Is patient covered by additional insurance:  YES  NO

Policy holder:  Same as patient  Same as guarantor

Policy ID: \_\_\_\_\_ Group # \_\_\_\_\_

Group Name: \_\_\_\_\_ Effective date of insurance: \_\_\_\_\_

Name of Insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ What is your copay for an office visit? \_\_\_\_\_

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