PATIENT INFORMATION

■ Patient Information

Name (Last, First, Middle) _____ Today's Date _____

Birthdate _____ **Soc. Sec. #** _____ **Home Phone** _____

Marital Status: _____ **Sex:** ☐ M ☐ F Cell Phone _____

Address _____ Work Phone _____

City _____ **State** _____ **Zip** _____

Email address _____ Permission to send newsletters/events by email: ☐ yes ☐ no

Northern Address _____ Phone_____

City _____ **State** _____ **Zip** _____

Referring Physician _____ Phone _____

Primary Care Physician _____

How did you hear about us: __Yellow pages __Friend __Website Doctor:_____ Other:_____

■ Primary Insurance (Complete even if we make a copy of your card)

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Secondary Insurance *(If not applicable, please cross out section.)*

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Assignment and Release

I hereby authorize payment directly to Bradenton Cardiology Center of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. **I have also been given a copy of Bradenton Cardiology Center's Financial Policy.**

Signature: _____ Date: _____

ATTN: MEDICARE PATIENTS – LIFETIME AUTHORIZATION

I request that payment of authorized Medicare and Medigap (if applicable) benefits be made on my behalf for any services furnished by the physicians of Bradenton Cardiology Center, P.A. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agent any information needed to determine these benefits for related services.

Signature: _____ Date: _____