Rev 7/23/18

PATIENT INFORMATION

■ Patient Information

☐ Bradenton office ☐ Lakewood Ranch office

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 sign up for patient portal:** ☐ **yes** ☐ **no**

Northern Address ______________________ Phone ______________

City ______________ **State** ______ **Zip** ________

Referring Physician ______________________ Phone ______________

Primary Care Physician ______________________

How did you hear about us: Yellow pages Friend/Family Website Event 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: ______________