PARKWAY CARDIOLOGY ASSOCIATES, PC

PATIENT INFORMATION

Patient Name _____ Birth Date_____
First Middle Last MM/DD/YY

Mailing Address _____
Street City State Zip

Home Phone _____ SS#_____

Cell Phone: _____ Sex: ____Male ____Female Marital Status: S M D W

Employer Name: _____ Address: _____

Employer Phone _____ Occupation _____

Family Physician _____ Address: _____

Primary Insurance _____ Secondary Insurance: _____
Please allow us to make a copy of your insurance card at time of visit. Notify our office if any change of insurance occurs.

Spouse's Name _____ SS# _____ Birth date _____

Spouse's Employer/Retired _____ Address: _____

Employer Phone _____ Occupation _____

In case of emergency, contact: _____ Relationship _____ Phone _____

Responsible Party Information (if other than Patient)

Responsible Party's Name _____ Birth date _____

Address _____ **Phone #** _____

SS# _____ Cell Phone# _____

Employer/Address _____ Relationship to Patient _____

Release of Information

I, hereby five Parkway Cardiology Associates permission to divulge my personal health information to the following (please indicate relationship). If additional space is needed, please attach a separate sheet.

_____ _____

_____ _____

Before releasing information, we may ask for your social security number and date of birth. Please make certain that authorized persons have this information before calling our office.

I hereby, give my permission for your office to leave messages regarding my personal health information on my [ ] home or [ ] office answering machines. [ ] N/A (I do not have an answering machine.)

I give my permission for you to leave personal health information messages with whomever answers my home phone [ ] Yes [ ] No

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Consent for Treatment and Testing: I hereby consent to medical treatment including routine diagnostic procedures and blood testing when considered necessary. **Release of Records**: I hereby authorize you to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such care to third payers and/or other health practitioners. **Minor**: If the patient is a minor (under 18 years of age) the legal guardian has authorized (by signing below) the treatment of the minor. **Assignment**: I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to the physician. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

PATIENT SIGNATURE_____ DATE _____