HEART SOUTH CARDIOVASCULAR GROUP, PC

Account #: ________ **PATIENT INFORMATION** Date:
A-Form last updated on:

SSN: ________ Drivers License #: ________

Patient Name: Last: ________ First Name: ________ Middle: ________

Address: ________

City: ________ State: ________ Zip: ________ Phone: ________ Cell Phone: ________

Email Address: ________ ☐ Male ☐ Female Birthdate: ________ Marital Status: ________

Scheduled Physician: ________ Referring Physician: ________ Primary Care Physician: ________

Who Referred You to Heart South? Physician: ________ Patient/Relative: ________

Other: ________

☐ Employed Full Time ☐ Employed Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military Duty ☐ Unknown

☐ Full Time Student ☐ Part Time Student ☐ Not a Student

Employer: ________ Phone: ________

Person Response for Account: Self ________ Relationship: ________

Address: ________

City: ________ State: ________ Zip: ________ Phone: ( ) -

Employer: ________ Phone: ( ) -

Person to notify in case of emergency: ________ Phone: ________

Have you arranged for a Living Will? (Advance Directives) ☐ Yes ☐ No Have you appointed a durable power of attorney? ☐ Yes ☐ No

INSURANCE POLICY INFORMATION

Insurance Company (Primary): ________

Insurance Company Address: ________

Policy Holder's Name: ________ Birthdate: ________

Employer: ________

Contract or Group: ________

Relationship of patient to policy holder: ________

Insurance Company (Secondary): ________

Insurance Company (Secondary) Address: ________

Policy Holder's Name: ________ Birthdate: ________

Employer: ________

Contract or Group: ________

Relationship of patient to policy holder: ________

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize the release of any and all my treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers. This includes psychological or psychiatric care, attention and treatment.

FINANCIAL INFORMATION - Insurance claims are submitted for the services provided by Heart South Cardiovascular Group, P.C. However, the payment of services remains the responsibility of the patient and/or responsible party.

SIGNATURE: ________ DATE: ________