PATIENT INFORMATION FORM

ALL BLANKS ARE TO BE COMPLETED:

Last Name: _________________________ **First Name:** __________________ **Middle Initial:** _______

Soc Sec #: _____________________ **Date of Birth:** _________________ **Age:** _____ **Sex:** ____ **Male** ____**Female**

RACE: ______________ **ETHNICITY:** ____**Latino** ____**Non-Latino** **PREFERRED LANGUAGE:** ________________________

Address: ____

Phone: ______________________ **Marital Status (Circle One): Single Married Widowed Divorced**

Name and Address of Employer: ____

____

Occupation: ____

PRIMARY INSURANCE COMPANY INFORMATION:

Insurance Company: ____ **ID#:** ___________________________

Group #: _____________________________ **Subscriber Name:** ____________________________________

Subscriber Social Security #: ___________________________ **Subscriber Date of Birth:** ______________

Subscriber Address: ____

Subscriber Relationship to Patient: _________________________________

SECONDARY INSURANCE COMPANY INFORMATION:

Insurance Company: ____ **ID#:** ___________________________

Group #: _____________________________ **Subscriber Name:** ____________________________________

Subscriber Social Security #: ___________________________ **Subscriber Date of Birth:** ______________

Subscriber Address: ____

Subscriber Relationship to Patient: _________________________________

NOTIFY IN CASE OF EMERGENCY: ____
PLEASE INDICATE ANY PERSON YOU WOULD LIKE US TO SHARE YOUR HEALTHCARE INFORMATION WITH BELOW:
____

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO ATLANTIC CARDIOLOGY FOR THE SERVICES RENDERED BY THEM IN PERSON OR UNDER THEIR SUPERVISION. THIS ASSIGNMENT WILL REMAIN EFFECTIVE UNLESS REVOKED BY ME IN WRITING TO THEM.

SIGNED: ____ **DATE:** _____________________________
(Patient or Guardian)

If you have any visual factors, auditory factors, language, cultural or religious customs that may impact your care, please notify the staff.