

# HEART & VASCULAR CLINIC

DATE: \_\_\_\_\_

ACCT # \_\_\_\_\_

<input type="checkbox"/> Male <input type="checkbox"/> Female  <b>STATUS</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other  <b>RESPONSIBLE PARTY</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	Last Name		First Name		Middle/Maiden	Date of Birth	
	Address					Age	
	City		State		Zip	Phone (Home)	
	Social Security Number			Driver's Lic. No.-LA		Work Related Injury <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Name of Employer/School					If Student, <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	
	Employer's Address					Phone (Work)	

<b>INSURANCE INFORMATION</b>	Primary Insurance		Secondary Insurance		
	Policy/Contract No.	Group No.	Policy/Contract No.	Group No.	
	Name Policy Holder		Name of Policy Holder		
	Date of Birth of Insured		Date of Birth of Insured		
	SEND CLAIMS TO:		SEND CLAIMS TO:		

Emergency Phone # other than home	Name	Relationship
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Family Physician	Phone	Heart & Vascular Physician
Referring Physician	Phone	Heart & Vascular Physician

<b>RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS</b>	<p>For Medical Services Rendered to Myself or Dependent(s), I Hereby Authorize The Following:</p> <p>A) Release of any information to obtain examination, treatment, and/or payment.</p> <p>B) Direct payment of Heart &amp; Vascular Clinic and/or Cardiovascular Imaging, Inc.</p> <p>C) Photocopies of this form to be as valid as the original.</p> <p>D) I request that payment of authorized Medicare benefits be made either to me or on my behalf to Heart &amp; Vascular Imaging, Inc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.</p> <p>I UNDERSTAND THAT HAVING INSURANCE COVERAGE DOES NOT RELEASE ME OF THIS LIABILITY.</p>	
	<p>Signature of Insured / Responsible Party</p>	
		Date