REGIONAL CARDIOLOGY ASSOCIATES, P.L.C.

PATIENT INFORMATION

DATE_____

Name (Last)_____ (First)_____ (MI)_____

Date of Birth_____ Age_____ Sex ☐M ☐F Marital Status ☐S ☐M ☐D☐ W

Address (Street)_____ Apt./Lot#_____

City, State_____ Zip Code_____ Social Security# _____

Phone#_____ Cell Phone #_____ Email Address_____

Employer Name_____ Address _____Phone_____

Referring Physician_____

Emergency Contact Name_____ Relationship _____Phone_____
(other than someone living in your home)

PRIMARY INSURANCE INFORMATION

Insurance Co_____ Contract#_____ Group_____

Insured's Name_____ Relationship_____ ☐ Self ☐ Spouse ☐ Dep.

Insured's Address _____ City, St_____ Zip Code_____

Insured's Employer_____ Insured's Social Security #_____

Insured's D.O.B._____ Sex ☐M ☐F

SECONDARY INSURANCE INFORMATION

Insurance Co_____ Contract#_____ Group_____

Insured's Name_____ Relationship_____ ☐ Self ☐ Spouse ☐ Dep.

Insured's Address _____ City, St_____ Zip Code_____

Insured's Employer_____ Insured's Social Security #_____

Insured's D.O.B._____ Sex ☐ M ☐ F

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to **Regional Cardiology Associates, P.L.C.**, realizing that I am responsible to pay for all charges whether or not they are covered by my insurance. I hereby authorize the release of pertinent medical information to the insurance carrier and their representative to determine these benefits.

I hereby authorize Regional Cardiology Associates, P.L.C. to release medical information and/or information contained within the medical records regarding but not limited to my physical condition, treatment rendered, findings, diagnosis and prognosis, drug, alcohol, psychiatric, AIDS, HIV information to referring physicians, hospitals, laboratories, therapists, and pain clinics in the course of my treatment under the care of a physician of Regional Cardiology Associates, P.L.C. This authorization shall remain valid until notice is given by me revoking said authorization.

_____ _____
Signature of Patient/ Guardian Signature of Witness

_____
Date