



PATIENT INFORMATION SHEET

PF08401 (R 8/07)

Account # _____ Date ____/____/____

Last _____ First _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

Sex M or F Birth Date ____/____/____ Social Security Number _____ - _____ - _____

Employer (or retired from) _____ Employer Phone _____

Date Retired _____

Family Doctor _____ Name _____ City _____

Cardiologist: _____ Name _____ Cardiovascular Surgeon _____ Name _____

Marital Status: Married Spouse's name _____ Single Divorced Widow(er)

Name and phone number of contact person not living with you:

Name _____ Phone _____ - _____ - _____ Relationship to you _____

INSURANCE INFORMATION:

Is Medicare Primary? _____ If NO, please explain: _____

Other insurance: _____ Subscriber: _____ DOB _____

Address: _____ Phone: _____

Group #: _____ Policy #: _____

Medicaid Recipient I.D. Number: _____

YOUR INSURANCE CANNOT BE BILLED WITHOUT COMPLETE INFORMATION

AUTHORIZATION AND RELEASE OF INFORMATION

I hereby authorize the physicians of Covenant Heart Specialists to furnish and/or obtain information to and/or from myself, insurance carriers, hospitals and physicians concerning my illness, surgery and/or accident. I assign to the physicians all payments for medical services rendered. I understand that I will be financially responsible for all charges whether or not they are covered by my insurance.

Patient's Signature: _____ Date: _____