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BOARD-CERTIFIED:
Internal Medicine,
Cardiovascular Diseases,
Interventional Cardiology
FELLOW: American
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Nuclear Cardiology,
Echocardiography

NEW PATIENT INFORMATION

PLEASE PRINT

Patient's Name: _____ Birthdate: _____

Mailing Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Cell/Alternate Phone: _____ Sex M F

Social Security #: _____ Marital Status: S M W D

Email Address: _____

Employer: _____ How long Employed: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Occupation: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

NEAREST RELATIVE (not living with you)

Name: _____ Phone: _____

SPOUSE'S INFORMATION

Spouse's Name: _____ Birthdate: _____

Social Security #: _____

Employer: _____ How long Employed: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Occupation: _____

INSURANCE INFORMATION

Medicare #: _____ Is Medicare: _____ Primary _____ Secondary

Have you ever participated in a Medicare replacement policy? ___ Y ___ N Is it active now? ___ Y ___ N

Medicaid #: _____

Commercial Insurance: _____

Precertification / Benefits Phone#: _____

ID or Policy #: _____ Group #: _____

Additional Commercial Insurance: _____

Precertification / Benefits Phone#: _____

ID or Policy #: _____ Group #: _____

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PLEASE READ AND SIGN

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY AUTHORIZE SOUTHWEST CARDIOVASCULAR TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN (S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND AND AGREE THAT AFTER SERVICES ARE RENDERED, GUARANTOR WILL BE RESPONSIBLE FOR ALL UNPAID CHARGES AND ANY AND ALL ADDITIONAL COLLECTION FEES.

SIGNATURE _____ DATE _____

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FOR STAFF USE ONLY

Account Number: _____ Appointment Date: _____

New Patient: _____ Established Patient: _____ Established/New Patient: _____

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