CAMP LOWELL CARDIOLOGY

Date: ________________ Patient Name: ____________________________ DOB: ________________

SS#: ________________________ Marital Status: S M W D Sex: M F

Telephone: (H) ____________________ (W) _____________________ (C) ________________________

Address: ____
Street City State Zip Code

Alternate Address: ____
Street City State Zip Code

E-mail Address: ____________________________ Employer: ___________________________________

Primary Care Physician: ________________________________ Phone: _________________________

Emergency Contact: _____________________ Phone: ______________ Relationship: _________________

INSURANCE INFORMATION

Primary Insurance: _________________________________ ID #: ______________________________

Name of Insured: ______________________________ DOB: ________________

Group #: ______________ Relationship to Patient: ___________________________

Secondary Insurance: _________________________________ ID #: ____________________________

Name of Insured: ______________________________ DOB: ________________

Group #: ______________ Relationship to Patient: ___________________________

Tertiary Insurance: _________________________________ ID #: ______________________________

Name of Insured: ______________________________ DOB: ________________

Group #: ______________ Relationship to Patient: ___________________________

I authorize the release of any medical information necessary to process any insurance claims. I permit a copy of this authorization to be used in place of the original. I authorize payment of medical benefits to Camp Lowell Cardiology for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductions, co-payments and co-insurance amounts.

My signature below attests to the accuracy and completeness of the information provided on this page; it also indicates my full understanding of the above information.

____ _________________________
Patient Signature Date