



PATIENT INFORMATION FORM
Patients must complete this form annually

Last Name: _____ First Name: _____ MI: _____

Birth date: _____ SSN: _____/_____/_____ Circle one: M F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph: (____) _____ Cell Ph: (____) _____ Work Ph: (____) _____

Employer: _____ Occupation: _____

Primary Care Physician: (last) _____ (first) _____ Referring Physician: _____

Spouse's Name: _____ Employer: _____

IN CASE OF AN EMERGENCY please notify (someone not living with you)

Name: _____ Relationship: _____ Home Ph: _____ Work/Cell: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Effective Date: _____

Policy Holder's Name: _____ Birth date: _____ Co-Pay \$: _____

Policy Holder's SSN: _____/_____/_____ Policy #: _____ Group#: _____

Secondary Insurance Company: _____ Effective Date: _____

Policy Holder's Name: _____ Birth date: _____ Co-Pay \$: _____

Policy Holder's SNN: _____/_____/_____ Policy#: _____ Group#: _____

IT IS THE PATIENT'S RESPONSIBILITY TO CHECK AND KNOW INSURANCE COMPANY COVERAGE, BENEFITS AND CONTRACTED PROVIDERS.

I understand that I am financially responsible for all charges for services rendered to me regardless of possible insurance coverage, including the balance after insurance payments. I authorize payment under my insurance programs to be made directly to me, or to the party accepting assignment. I authorize the release of any medical information covered by "The Privacy Act: necessary to process the claim or to assist any physicians who might be involved in my care.

WHO DO YOU AUTHORIZE BILTMORE CARDIOLOGY TO RELEASE MEDICAL INFORMATION TO (VERBAL instructions, lab results, or test results) SUCH AS spouse, other family members, attorney, etc:

Medical Records copies require a separate signed release

Name: _____ Relationship to Patient: _____

I authorize my medical records to be faxed to: () _____.

Patient Signature

If we are unable to contact you in person, may we leave a message in reference to your healthcare results and/or information on your home answering machine? ♥YES ♥NO _____ patient initials

I acknowledge "Patient Disclosure of Protected Health Information" made available to me: _____ patient initials

Signature of Patient and/or Guardian Date