

HUNTERDON CARDIOVASCULAR ASSOCIATES, P.A.

Patient Information

Last Name _____ First Name _____ M.I. _____
Address _____ Apt. _____
City _____ State _____ Zip _____
Social Security # _____ Birth Date _____
Home Phone (____) _____ Cell Phone # (____) _____ Work Phone # (____) _____ Ext. _____
Marital Status Single Married Divorced Widowed Sex Male Female

Insurance Information - Primary / Secondary / Other

*****Please Give Your Insurance Cards To The Receptionist*****

Is this office visit related to a workman's compensation case? Yes No or Motor vehicle accident? Yes No
Do you have health insurance? Yes No Copay Yes No Amount \$ _____
Primary Insurance _____ Address _____
Please Indicate the policyholder
Policy No. _____ Group No. _____ for the primary insurance: Self Spouse
Copay Yes No Amount \$ _____
Secondary Insurance _____ Address _____
Please Indicate the policyholder
Policy No. _____ Group No. _____ for the primary insurance: Self Spouse
Copay Yes No Amount \$ _____

Patient's Employer Information

Employer's Name _____ Patient's Occupation _____
Address _____ City _____ State _____ Zip _____ Telephone # _____

Spouse's Information (If Patient is covered by Spouse's Insurance)

Spouse's Name _____ Spouse's Birth Date _____
Spouse's SS# _____ Employer's Phone # (____) _____
Spouse's Employer _____
Spouse's Employer's Address _____ State _____ Zip _____

Emergency Information

In case of an emergency, we may contact: _____
Phone # (____) _____ Relationship to Patient _____

Primary Care / Referring Physician Information

Your Primary Care Physician's Name: _____ Telephone # _____
Address _____ Release Information to PCP? Yes No

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Hunterdon Cardiovascular Associates, its successors and assigns, or any individual it may designate for services provided.

I hereby agree that I am financially responsible to Hunterdon Cardiovascular Associates, for all Copays, coinsurance, deductibles and fees for non-covered services which are rendered to me.

Signature of Patient or Parent of Minor _____ Date _____

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Hunterdon Cardiovascular Associates, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services and its agents any information needed to determine these benefits or the benefits payment for related services.

Signature of Patient or Parent of Minor _____ Date _____

PATIENT INFORMATION FORM

Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and health care operations (as defined in the Notice). We may leave messages on your answering machine; we may call your place of employment to give you information about your visit; we may discuss your care with a caregiver who brings you to our office, or to relatives that have shown interest in your care; we may discuss your medications, blood work, tests results with you on the phone or at our nurses station; we may schedule appointments for follow-up visits or diagnostic tests while you are in our check out area. If this is understood and agreeable, please sign and date below:

Signature _____ Date _____