Freedman Memorial Cardiology

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(1941-2018)
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PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

PATIENT MR. MRS. MISS/MS. | FIRST | MIDDLE | LAST

PATIENT ADDRESS: | STREET | CITY | STATE | ZIP

DATE OF BIRTH: | SOCIAL SECUTIY NUMBER: | HOME PHONE:

PATIENT EMPLOYER: | WORK PHONE:

CELL PHONE: | E-MAIL ADDRESS:

SPOUSE'S NAME: | SOCIAL SECURITY NUMBER: | EMPLOYER:

EMERGENCY CONTACT (Individual Not Living in Your Household) | NAME: | PHONE:

↓ MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

SECONDARY INSURANCE COMPANY:

OTHER INSURANCE COMPANY:

↓ IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION

RESPONSIBLE PARTY MR. MRS. MISS/MS. | PHONE:

ADDRESS: | STREET | CITY | STATE | ZIP

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.

METHOD OF PAYMENT: CHECK_____ CREDIT CARD_____

PLEASE READ AND SIGN THE FOLLOWING:
I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO FREEDMAN MEMORIAL CARDIOLOGY FOR ANY SERVICES FURNISHED ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER AND/OR HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS AND/OR MY MEDIGAP INSURER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

Signature_____ Date_____

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