CARDIOVASCULAR INSTITUTE
OF NORTHWEST FLORIDA

801 E. 6th Street, Suite 504, Panama City FL 32401
Phone: 850-769-0329 Fax: 850-769-3008

PATIENT INFORMATION SHEET

DATE: _____/_____/_____ **DOB: _____/_____/_____ AGE: _____**

PATIENT'S NAME (LAST): _____ (FIRST) :_____(MI):_____ MARITAL STATUS:_____

SOCIAL SECURITY #: _____-_____-_____ SEX: Male ____ Female ____ EMAIL: _____

LOCAL ADDRESS: _____
Street # City State Zip

SECONDARY ADDRESS: _____
Street # City State Zip

HOME NUMBER: (_____) _____-_____ CELL PHONE: (_____) _____-_____ WORK NUMBER: (_____) _____-_____

OCCUPATION: _____ EMPLOYER: _____

NAME OF REFERRING PHYSICIAN: _____

NOTIFY IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP: _____PHONE: (_____) _____-_____

PLACE OF EMPLOYMENT: _____ WORK NUMBER: (_____) _____-_____

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INSURANCE INFORMATION

Name of Primary Insurance: _____ Policy/Member #:_____ Group #:_____

Policy Holder/Subscriber Name: _____ DOB: ____/____/_____ Sex: _____ Relationship to Patient: _____

Name of Secondary Insurance: _____ Policy/Member #:_____ Group #:_____

Policy Holder/Subscriber Name: _____ DOB: ____/____/_____ Sex: _____ Relationship to Patient: _____

INSURANCE ASSIGNMENT OF BENEFITS & PAYMENT POLICY

I attest that I have read and understand the following:

I request that payment of authorized Medicare and/or Medical Insurance benefits whether primary or secondary benefits be made on my behalf to Cardiovascular Institute of NW Florida for any services furnished to me by Cardiovascular Institute of NW Florida.

I authorize Cardiovascular Institute of NW Florida to furnish any of my insurance companies and/or its agents all medical records necessary to determine benefits for services provided to me.

I understand that I am financially responsible for charges when services are rendered and that payment of deductibles and coinsurance are required at the time of service for all services.

Patient Signature: _____ **Date Signed**: _____

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Only complete the following portion if you would like for us to be able to discuss your Cardiovascular Institute of NW Florida medical or billing information with another person of your choosing.

I AUTHORIZE THE PHYSICIANS AND STAFF OF CARDIOVASCULAR INSTITUTE OF NW FLORIDA TO DISCUSS OR RELEASE MY MEDICAL RECORDS, CLINICAL INFORMATION AND OR BILLING INFORMATION WITH THE FOLLOWING INDIVIDUAL:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

SIGNATURE OF PATIENT_____ DATE_____

(This authorization will remain in effect until it is revoked in writing and may be revoked in writing at any time.)