CARDIOVASCULAR INSTITUTE
OF NORTHWEST FLORIDA

11111 Panama City Beach Pkwy, Ste. 109
Panama City Beach, FL 32407
Phone: 850-769-0329

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: (_____) _____-_____

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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RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of the Cardiovascular Institute of Northwest Florida Privacy Practices which states how we may use and/or disclose your health information. Please sign here to acknowledge that you have received a copy.

Patient Name (Printed) _____

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 <u>Cardiovascular Institute of NW Florida</u> 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.)