Welcome to Our Office

ID # ______________

Doctor ____________

PATIENT INFORMATION

PATIENTS NAME *(PLEASE PRINT)* LAST	FIRST	MIDDLE INITIAL
STREET ADDRESS	CITY AND STATE	ZIP CODE
HOME PHONE # ( ) / SEX / MARITIAL STATUS	BIRTH DATE / AGE	S.S. #
PATIENT'S EMPLOYER / OCCUPATION	HOW LONG EMPLOYED	BUS. PHONE # ( )
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE
EMERGENCY CONTACT *(NOT LIVING WITH YOU)* - RELATIONSHIP	ADDRESS	PHONE #

SPOUSE'S NAME LAST FIRST MIDDLE INITIAL	BIRTH DATE	S.S. #
SPOUSE'S EMPLOYER / OCCUPATION	HOW LONG EMPLOYED	BUS. PHONE # ( )
EMPLOYERS STREET ADDRESS	CITY AND STATE	ZIP CODE

PERSON RESPONSIBLE FOR BILL [ ] CHECK HERE IF PATIENT

HEALTH INSURANCE INFORMATION

NAME OF INSURANCE COMPANY - *PRIMARY*	NAME OF INSURANCE COMPANY - *SECONDARY*
MAIL CLAIMS TO:	MAIL CLAIMS TO:
CERTIFICATE #	CERTIFICATE #
GROUP # / EFFECTIVE DATE	GROUP # / EFFECTIVE DATE
NAME OF POLICY HOLDER - RELATIONSHIP	NAME OF POLICY HOLDER - RELATIONSHIP

REFERRED BY: FIRST NAME / LAST NAME	STREET ADDRESS	CITY AND STATE	ZIP CODE	PHONE #

Was the patient seen in the hospital or E.R.? If so, which hospital?

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/Other insurance company benefits be made on my behalf to Carolina Heart Specialists, LLC for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize Carolina Heart Specialists, LLC to release information necessary for payment of their services. I also authorize Carolina Heart Specialist, LLC, and it's agents, to appeal to the insurance company(ies) for payment of claims for services rendered to me, which are denied by my insurance policy(ies).

I authorize the release of medical or other information about me to referring or referred physicians involved in my medical care.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I understand that I am responsible for all medical expenses uncured regardless of whether there is insurance and the status of such.

SIGNATURE **DATE**