Patient Name _____
M☐ F☐
First Name *Middle Initial* *Last Name*
*Social Security #*_____ *Home Phone* _____*Birth Date* _____

Address _____*City* _____ *State* _____ *Zip* _____

ALLERGIES TO MEDICATION:
_____

Name & Address of Primary Care Physician:
_____

PERSON responsible for this account:
_____

Relationship to patient _____ *Birth Date* _____ *Soc. Sec #* _____

Address (if different from patient)
_____
City *State* *Zip*
Employer _____*Cell Phone* _____*Work Phone* _____

Spouse _____ *Birth Date* _____ *Soc. Sec #* _____

Address (if different from patient)
_____

Employer _____*Cell Phone*_____*Work Phone* _____

Name of Primary Insurance Holder: _____*Relationship* _____

Address & Phone #:
_____

Insurance Company Name & Address
_____

Policy # _____ *Group #* _____*Co Pay* *$*_____

PLEASE PRESENT YOUR INSURANCE CARD FOR PHOTOCOPYING

Name of Secondary Insurance Holder: _____Relationship _____

Address & Phone #:

_____

Insurance Company Name & Address

_____

Policy # _____ Group # _____Co Pay $ _____

I authorize the release of medical information necessary to process insurance claims. I permit a copy of this authorization to be used in the place of the original. I hereby authorize Pediatric Cardiology to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Pediatric Cardiology Associates.

*I understand that if appropriate **PRIOR** authorization from my Primary Care Physician and my insurance company, or because the appropriate approval cannot be verified, the services may not be covered. I further acknowledge that I am aware that I can be held personally responsible for payment of some or all medical expenses incurred.*

Signature_____ Date _____