Cardiology Associates of Fredericksburg, Ltd.

Patient Information

Name ______________________________ Age __________

Address ______________________________ City __________ State ______ Zip __________

Home Telephone (______)__________ Work Telephone (______)__________ Email__________

Sex ________ Date of Birth ______/______/______ Race __________ Marital Status__________

Social Security Number ________/______/________ Occupation__________

Employer ______________________________

Employer's Address ______________________________

Emergency Contact Person ______________________________ Telephone (______)__________

Spouse Information ☐ Responsible Party ☐

Name ______________________________ Age __________

Address ______________________________ City __________ State ______ Zip __________

Home Telephone (______)__________ Work Telephone (______)__________ Email__________

Sex ________ Date of Birth ______/______/______ Race __________ Marital Status__________

Social Security Number ________/______/________ Occupation__________

Employer ______________________________

Employer's Address ______________________________

Medical Information

Referring Doctor's Name ______________________________ Address ______________________________

Family Doctor's Name ______________________________ Address ______________________________

Drug Allergies ______________________________ Pharmacy ______________________________

Time of Accident ______________ Workman's Compensation? ☐ Yes ☐ No Claim # ______________

If you have a family member of friend who helps you with your appointments, medicines or billing and you would like for us to discuss your care with them, please list their name and phone number here.

Name ______________________________ Telephone (______)__________

Insurance Information

Primary Insurance Name ______________________________ Subscriber's Name ______________________________

Relationship to Policyholder (circle one) 1. Policyholder 2. Spouse 3. Child 4. Other Subscriber's Date of Birth ______/______/______

Policy ID # ______________________________ Group # ______________________________

Secondary Insurance Name ______________________________ Subscriber's Name ______________________________

Relationship to Policyholder (circle one) 1. Policyholder 2. Spouse 3. Child 4. Other Subscriber's Date of Birth ______/______/______

Policy ID # ______________________________ Group # ______________________________

I hereby authorize Cardiology Associates of Fredericksburg, Ltd. to release necessary medical information to my physician(s) and / or my insurance company(ies). I further authorize direct payment to the above entitled from the above listed companies, if any. I understand that I am responsible for obtaining referrals, if necessary, and any co-payment or deductibles required by my plan. I accept the responsibility for any and all collection fees, if my account becomes delinquent and is submitted for further collection.

Patient Signature ______________________________

Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ______________________________ Date of Birth ______________

Signature ______________________________ Date ______________