CAROLINA CARDIOLOGY ASSOCIATES

Name_____Date of Birth_____

Race: _____ Male / Female Social Security #_____

Address: _____

City: _____ State_____ Zip_____

Phone (Home) _____ Cell# _____

Business Phone: _____Email Address:_____

Family Physician: _____

Referring Doctor (IF DIFFERENT FROM ABOVE)_____

Insurance 1_____Copay if any $_____

Insurance 2_____

Have you been seen in the hospital or ER recently? Yes / No

If so which hospital were you seen?_____

Do you have Veteran Health Benefits? Yes / No

Emergency Contacts:

Name Number

_____

_____

I hereby authorize payment of medical benefits directly to Carolina Cardiology Associates, P. A., If any, otherwise Payable by me for services rendered on my behalf. I also authorize Carolina Cardiology Associates, P. A. to release medical information to process insurance claims and to other physicians, hospitals or other healthcare institutions to aid in medical treatment. This authorization applies to all occasions of service until revoked. I attest that the above information is correct and complete to the best of my knowledge.

SIGNATURE:_____DATE:_____